

106TH CONGRESS  
2D SESSION

# S. 3165

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

OCTOBER 5 (legislative day, SEPTEMBER 22), 2000

Mr. ROTH (for himself, Mr. MOYNIHAN, Mr. JEFFORDS, Mr. MURKOWSKI, Mr. HATCH, and Mr. KERREY) introduced the following bill; which was read the first time

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## A BILL

To amend the Social Security Act to make corrections and refinements in the Medicare, Medicaid, and SCHIP health insurance programs, as revised by the Balanced Budget Act of 1997 and the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECUR-**  
 2 **RITY ACT; REFERENCES TO OTHER ACTS;**  
 3 **TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the  
 5 “Medicare, Medicaid, and SCHIP Balanced Budget Re-  
 6 finement Act of 2000”.

7 (b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Ex-  
 8 cept as otherwise specifically provided, whenever in this  
 9 Act an amendment is expressed in terms of an amendment  
 10 to or repeal of a section or other provision, the reference  
 11 shall be considered to be made to that section or other  
 12 provision of the Social Security Act.

13 (c) **REFERENCES TO OTHER ACTS.**—In this Act:

14 (1) **THE BALANCED BUDGET ACT OF 1997.**—  
 15 The term “BBA” means the Balanced Budget Act  
 16 of 1997 (Public Law 105–33; 111 Stat. 251).

17 (2) **THE MEDICARE, MEDICAID, AND SCHIP**  
 18 **BALANCED BUDGET REFINEMENT ACT OF 1999.**—  
 19 The term “BBRA” means the Medicare, Medicaid,  
 20 and SCHIP Balanced Budget Refinement Act of  
 21 1999 (113 Stat. 1501A–321), as enacted into law by  
 22 section 1000(a)(6) of Public Law 106–113.

23 (d) **TABLE OF CONTENTS.**—The table of contents of  
 24 this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to other acts;  
 table of contents.

## TITLE I—BENEFIT IMPROVEMENTS

## Subtitle A—Beneficiary Assistance

- Sec. 101. Limiting copayment amount for hospital outpatient services.
- Sec. 102. Coverage of immunosuppressive drugs.
- Sec. 103. Preservation of coverage of drugs and biologicals under part B of the medicare program.
- Sec. 104. Moratorium on reductions in current reimbursement rates for outpatient drugs and biologicals; GAO study and report and HHS comments.

## Subtitle B—Improved Preventive Benefits

- Sec. 111. Coverage of biannual screening pap smear and pelvic exams.
- Sec. 112. Coverage of screening colonoscopy for average risk individuals.
- Sec. 113. Medical nutrition therapy services for beneficiaries with diabetes, a cardiovascular disease, or a renal disease.
- Sec. 114. State accreditation of diabetes self-management training programs.
- Sec. 115. Studies on preventive interventions in primary care for older Americans.
- Sec. 116. Institute of Medicine 3-year medicare prevention benefit study and report.
- Sec. 117. MedPAC study and report on medicare coverage of cardiac and pulmonary rehabilitation therapy services.

## TITLE II—RURAL HEALTH CARE IMPROVEMENTS

## Subtitle A—Critical Access Hospital Provisions

- Sec. 201. Clarification of no beneficiary cost-sharing for clinical diagnostic laboratory tests furnished by critical access hospitals.
- Sec. 202. Revision of payment for professional services provided by a critical access hospital.
- Sec. 203. Permitting critical access hospitals to operate PPS exempt distinct part psychiatric and rehabilitation units.
- Sec. 204. Exemption of critical access hospital swing beds from SNF PPS.

## Subtitle B—Other Rural Hospital Provisions

- Sec. 211. Equitable treatment for rural disproportionate share hospitals.
- Sec. 212. Option to base eligibility for medicare dependent, small rural hospital program on discharges during any of the 3 most recent audited cost reporting periods.
- Sec. 213. Extension of option to use rebased target amounts to all sole community hospitals.
- Sec. 214. MedPAC analysis of impact of volume on per unit cost of rural hospitals with psychiatric units.

## Subtitle C—Other Rural Provisions

- Sec. 221. Provider-based rural health clinic cap exemption.
- Sec. 222. Payment for certain physician assistant services.
- Sec. 223. Temporary increase for home health services furnished in a rural area.
- Sec. 224. Refinement of medicare reimbursement for telehealth services.
- Sec. 225. MedPAC study on low-volume, isolated rural health care providers.

## TITLE III—PROVISIONS RELATING TO PART A

## Subtitle A—PPS Hospitals

- Sec. 301. Delay of reduction in PPS hospital payment update.
- Sec. 302. Revision of reduction of indirect graduate medical education payments.
- Sec. 303. Decrease in reductions for disproportionate share hospital payments.
- Sec. 304. Modification of payment rate for Puerto Rico hospitals.
- Sec. 305. MedPAC study and report on hospital area wage indexes.
- Sec. 306. MedPAC study and report regarding certain hospital costs.

## Subtitle B—PPS Exempt Hospitals

- Sec. 311. Permanent guarantee of pre-BBA payment levels for outpatient services furnished by children's hospitals.
- Sec. 312. Payment for inpatient services of rehabilitation hospitals.
- Sec. 313. Implementation of prospective payment system for long-term care hospitals.

## Subtitle C—Skilled Nursing Facilities

- Sec. 321. Revision to the skilled nursing facility (SNF) market basket update for fiscal years 2001 and 2002.
- Sec. 322. Application of SNF consolidated billing requirement limited to part A covered stays.
- Sec. 323. Reexamination of, and authority to revise, the skilled nursing facility market basket percentage increase.

## Subtitle D—Hospice Care

- Sec. 331. Revision of market basket increase for 2001 and 2002.
- Sec. 332. Study and report on physician certification requirement for hospice benefits.
- Sec. 333. Hospice demonstration program and hospice education grants.

## Subtitle E—Other Provisions

- Sec. 341. Six-month delay in implementation of rule regarding provider-based criteria.

## TITLE IV—PROVISIONS RELATING TO PART B

## Subtitle A—Hospital Outpatient Services

- Sec. 401. Application of transitional corridor to certain hospitals that did not submit a 1996 cost report.
- Sec. 402. Clarifying process and standards for determining eligibility of devices for pass-through payments under hospital outpatient PPS.
- Sec. 403. Contrast enhanced diagnostic procedures under hospital prospective payment system.
- Sec. 404. Transitional pass-through for contrast agents.

## Subtitle B—Provisions Relating to Physicians

- Sec. 411. MedPAC study on the resource-based practice expense system.
- Sec. 412. GAO studies and reports on medicare payments.
- Sec. 413. GAO study on gastrointestinal endoscopic services furnished in physicians' offices and hospital outpatient department services.

### Subtitle C—Ambulance Services

- Sec. 421. Elimination of reduction in inflation adjustments for ambulance services.
- Sec. 422. Election to forego phase-in of fee schedule for ambulance services.
- Sec. 423. Study and report on the costs of rural ambulance services.
- Sec. 424. GAO study and report on the costs of emergency and medical transportation services.

### Subtitle D—Other Services

- Sec. 431. Revision of moratorium in caps for therapy services.
- Sec. 432. Update in renal dialysis composite rate.
- Sec. 433. Full update in 2001 for durable medical equipment, oxygen, and oxygen equipment.
- Sec. 434. National limitation amount equal to 100 percent of national median for new pap smear technologies and other new clinical laboratory test technologies.
- Sec. 435. Delay and revision of PPS for ambulatory surgical centers.
- Sec. 436. Treatment of certain physician pathology services.
- Sec. 437. Modification of medicare billing requirements for certain Indian providers.
- Sec. 438. Replacement of prosthetic devices and parts.
- Sec. 439. MedPAC study and report on medicare reimbursement for services provided by certain providers.
- Sec. 440. MedPAC study and report on medicare coverage of services provided by certain non-physician providers.

## TITLE V—PROVISIONS RELATING TO PARTS A AND B

### Subtitle A—Home Health Services

- Sec. 501. 1-year additional delay in application of 15 percent reduction on payment limits for home health services.
- Sec. 502. Restoration of full home health market basket update for home health services for fiscal year 2001.
- Sec. 503. Exclusion of certain nonroutine medical supplies under the PPS for home health services.
- Sec. 504. Treatment of branch offices; GAO study on supervision of home health care provided in isolated rural areas.
- Sec. 505. Temporary additional payments for high-cost patients.
- Sec. 506. Clarification of the homebound definition under the medicare home health benefit.

### Subtitle B—Direct Graduate Medical Education

- Sec. 511. Authority to include costs of training of clinical psychologists in payments to hospitals.

## TITLE VI—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

### Subtitle A—Medicare+Choice Payment Reforms

- Sec. 601. Increase in national per capita medicare+choice growth percentage in 2001 and 2002.
- Sec. 602. Removing application of budget neutrality for 2002.

- Sec. 603. Increase in minimum payment amount.
- Sec. 604. Allowing movement to 50:50 percent blend in 2002.
- Sec. 605. Increased update for payment areas with only one or no medicare+choice contracts.
- Sec. 606. 10-year phase-in of risk adjustment and new methodology.
- Sec. 607. Permitting premium reductions as additional benefits under medicare+choice plans.
- Sec. 608. Delay from July to November 2000, in deadline for offering and withdrawing medicare+choice plans for 2001.
- Sec. 609. Revision of payment rates for ESRD patients enrolled in medicare+choice plans.
- Sec. 610. Modification of payment rules for certain frail elderly medicare beneficiaries.
- Sec. 611. Full implementation of risk adjustment for congestive heart failure enrollees for 2001.
- Sec. 612. Inclusion of costs of DOD military treatment facility services to medicare-eligible beneficiaries in calculation of medicare+choice payment rates.

#### Subtitle B—Other Medicare+Choice Reforms

- Sec. 621. Amounts in medicare trust funds available for Secretary's share of medicare+choice education and enrollment-related costs.
- Sec. 622. Special medigap enrollment antidiscrimination provision for certain beneficiaries.
- Sec. 623. Restoring effective date of elections and changes of elections of medicare+choice plans.
- Sec. 624. Permitting ESRD beneficiaries to enroll in another medicare+choice plan if the plan in which they are enrolled is terminated.
- Sec. 625. Election of uniform local coverage policy for medicare+choice plan covering multiple localities.

#### Subtitle C—Other Managed Care Reforms

- Sec. 631. Revised terms and conditions for extension of medicare community nursing organization (CNO) demonstration project.
- Sec. 632. Service area expansion for medicare cost contracts during transition period.

### TITLE VII—MEDICAID

- Sec. 701. New prospective payment system for Federally-qualified health centers and rural health clinics.
- Sec. 702. Medicaid DSH allotments.
- Sec. 703. Permanent extension of payment of medicare part B premiums for qualified medicare beneficiaries with income up to 135 percent of poverty.
- Sec. 704. Streamlined approval of continued State-wide section 1115 medicaid waivers.
- Sec. 705. Alaska FMAP.

### TITLE VIII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

- Sec. 801. Special rule for redistribution and availability of unused fiscal year 1998 and 1999 SCHIP allotments.
- Sec. 802. Presumptive eligibility under SCHIP.

Sec. 803. Authority to pay medicaid expansion SCHIP costs from title XXI appropriation.

#### TITLE IX—OTHER PROVISIONS

Sec. 901. Increase in authorization of appropriations for the maternal and child health services block grant.

Sec. 902. Increase in appropriations for special diabetes programs for children with type I diabetes and Indians.

## **TITLE I—BENEFIT IMPROVEMENTS Subtitle A—Beneficiary Assistance**

### **SEC. 101. LIMITING COPAYMENT AMOUNT FOR HOSPITAL OUTPATIENT SERVICES.**

(a) IN GENERAL.—Section 1833(t)(8)(C) (42 U.S.C. 1395l(t)(8)(C)) is amended—

(1) in the heading, by striking “TO INPATIENT HOSPITAL DEDUCTIBLE AMOUNT”; and

(2) by striking “exceed the amount” and all that follows before the period and inserting “exceed an amount equal to the greater of—

“(i) one-half of the amount of the inpatient hospital deductible established under section 1813(b) for that year; or

“(ii) 20 percent of the payment amount determined under this subsection for the procedure.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to services furnished on or after January 1, 2001.

1 **SEC. 102. COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.**

2 (a) **ELIMINATION OF TIME LIMITATION FOR COV-**  
 3 **ERAGE OF IMMUNOSUPPRESSIVE DRUGS.—**

4 (1) **IN GENERAL.**—Section 1861(s)(2)(J) (42  
 5 U.S.C. 1395x(s)(2)(J)) is amended to read as fol-  
 6 lows:

7 “(J) prescription drugs used in immuno-  
 8 suppressive therapy furnished to an individual  
 9 who—

10 “(A) receives an organ transplant for  
 11 which payment is made under this title; or

12 “(B) received an organ transplant during  
 13 the 36-month period immediately preceding the  
 14 individual’s most recent effective date of cov-  
 15 erage of benefits under this part.”.

16 (2) **CONFORMING AMENDMENTS.—**

17 (A) **EXTENDED COVERAGE.**—Section 1832  
 18 (42 U.S.C. 1395k) is amended—

19 (i) by striking subsection (b); and

20 (ii) by redesignating subsection (c) as  
 21 subsection (b).

22 (B) **PASS-THROUGH; REPORT.**—Sub-  
 23 sections (c) and (d) of section 227 of BBRA  
 24 (113 Stat. 1501A–355) are repealed.



1 (b) CONTINUED ENTITLEMENT FOR IMMUNO-  
2 SUPPRESSIVE DRUGS FOR CERTAIN INDIVIDUALS AFTER  
3 MEDICARE BENEFITS END.—

4 (1) IN GENERAL.—Section 226A(b)(2) (42  
5 U.S.C. 426–1(b)(2)) is amended by inserting “(ex-  
6 cept for the provision of immunosuppressive drugs  
7 pursuant to section 1861(s)(2)(J))” after “shall  
8 end”.

9 (2) APPLICATION.—In the case of an individual  
10 whose eligibility for benefits under title XVIII of the  
11 Social Security Act (42 U.S.C. 1395 et seq.) has  
12 ended except for the provision of immunosuppressive  
13 drugs pursuant to the amendment made by para-  
14 graph (1), such individual shall be deemed to be en-  
15 rolled in the original medicare fee-for-service pro-  
16 gram for purposes of receiving coverage of such  
17 drugs.

18 (3) TECHNICAL AMENDMENT.—Subsection (c)  
19 of section 226A (42 U.S.C. 426–1), as added by sec-  
20 tion 201(a)(3)(D)(ii) of the Social Security Inde-  
21 pendence and Program Improvements Act of 1994  
22 (Public Law 103–296; 108 Stat. 1497), is redesign-  
23 nated as subsection (d).

24 (c) EFFECTIVE DATE.—The amendments made by  
25 this section shall apply to immunosuppressive drugs fur-

1 nished on or after January 1, 2000, to individuals whose  
 2 period of entitlement (without regard to the amendment  
 3 made by subsection (b)(1)) to such drugs under title  
 4 XVIII of the Social Security Act ends after such date.

5 **SEC. 103. PRESERVATION OF COVERAGE OF DRUGS AND**  
 6 **BIOLOGICALS UNDER PART B OF THE MEDI-**  
 7 **CARE PROGRAM.**

8 (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
 9 1395x(s)(2)) is amended, in each of subparagraphs (A)  
 10 and (B), by striking “(including drugs and biologicals  
 11 which cannot, as determined in accordance with regula-  
 12 tions, be self-administered)” and inserting “(including  
 13 injectable and infusable drugs and biologicals which are  
 14 not usually self-administered by the patient)”.

15 (b) PRESERVING EXISTING COVERAGE OF  
 16 INJECTABLE AND INFUSABLE DRUGS AND  
 17 BIOLOGICALS.—

18 (1) REPORT TO CONGRESS REQUIRED BEFORE  
 19 COVERAGE IS LIMITED OR TERMINATED.—Notwith-  
 20 standing any other provision of law, beginning on  
 21 the date of enactment of this Act, the Secretary of  
 22 Health and Human Services (in this subsection re-  
 23 ferred to as the “Secretary”) may not limit or termi-  
 24 nate coverage (or permit an agency or organization  
 25 with a contract under section 1816 or 1842 of the

1 Social Security Act (42 U.S.C. 1395h; 42 U.S.C.  
2 1395u) to limit or terminate coverage) of any  
3 injectable or infusable drug or biological that was re-  
4 imbursed (as determined under policies established  
5 by each such agency or organization) under section  
6 1861(s)(2) of such Act (42 U.S.C. 1395x(s)(2)) on  
7 January 1, 2000, solely on the basis that the drug  
8 or biological can be self-administered. This para-  
9 graph shall apply to any such drug or biological  
10 until the date that is 60 days after the date on  
11 which the Secretary submits to Congress a report  
12 described in paragraph (2) with respect to such drug  
13 or biological.

14 (2) REPORT DESCRIBED.—A report described  
15 in this paragraph is a report that describes in  
16 detail—

17 (A) the action the Secretary (or any agen-  
18 cy or organization described in paragraph (1))  
19 proposes to take with respect to the limitation  
20 or termination of coverage of an injectable or  
21 infusable drug or biological under section  
22 1861(s)(2) of the Social Security Act (42  
23 U.S.C. 1395x(s)(2)); and

24 (B) the reasons for taking such action.

1 (c) EFFECTIVE DATE.—The amendment made by  
 2 subsection (a) shall apply to drugs and biologicals fur-  
 3 nished on or after October 1, 2000.

4 **SEC. 104. MORATORIUM ON REDUCTIONS IN CURRENT RE-**  
 5 **IMBURSEMENT RATES FOR OUTPATIENT**  
 6 **DRUGS AND BIOLOGICALS; GAO STUDY AND**  
 7 **REPORT AND HHS COMMENTS.**

8 (a) MORATORIUM.—Notwithstanding any other pro-  
 9 vision of law, the Secretary of Health and Human Services  
 10 may not implement any reduction in the rate of reimburse-  
 11 ment for any outpatient drug or biological under the medi-  
 12 care program under title XVIII of the Social Security Act  
 13 (42 U.S.C. 1395 et seq.) during the period that begins  
 14 on the date of enactment of this Act and ends on Sep-  
 15 tember 15, 2001.

16 (b) GAO STUDY AND REPORT REGARDING REIM-  
 17 BURSEMENT RATES FOR OUTPATIENT DRUGS AND  
 18 BIOLOGICALS.—

19 (1) STUDY.—

20 (A) IN GENERAL.—The Comptroller Gen-  
 21 eral of the United States shall conduct a study  
 22 on the reasonableness of the reimbursement  
 23 policy for outpatient drugs and biologicals  
 24 under the medicare program under title XVIII  
 25 of the Social Security Act (42 U.S.C. 1395 et

1           seq.) based on the average wholesale price of  
2           such drugs.

3           (B) REQUIREMENTS.—The study described  
4           in subparagraph (A) shall include an examina-  
5           tion of the purchase prices providers pay for  
6           such drugs and biologicals and an identification  
7           of the factors that affect such purchase prices.

8           (2) REPORT.—Not later than July 1, 2001, the  
9           Comptroller General of the United States shall sub-  
10          mit to the Secretary of Health and Human Services  
11          and Congress a report on the study conducted under  
12          paragraph (1) together with recommendations for  
13          such legislation and administrative actions as the  
14          Comptroller General considers appropriate regarding  
15          any adjustment in payment policy necessary to en-  
16          sure reasonable reimbursement for outpatient drugs  
17          and biologicals under the medicare program.

18          (c) COMMENTS.—Not later than 90 days after the  
19          date on which the Comptroller General of the United  
20          States submits the report under subsection (b) to the Sec-  
21          retary of Health and Human Services, the Secretary shall  
22          submit comments on such report to Congress.

1     **Subtitle B—Improved Preventive**  
 2                     **Benefits**

3     **SEC. 111. COVERAGE OF BIENNIAL SCREENING PAP SMEAR**  
 4                     **AND PELVIC EXAMS.**

5             (a) IN GENERAL.—

6                 (1) BIENNIAL SCREENING PAP SMEAR.—Sec-  
 7             tion 1861(nm)(1) (42 U.S.C. 1395x(nm)(1)) is  
 8             amended by striking “3 years” and inserting “2  
 9             years”.

10                (2) BIENNIAL SCREENING PELVIC EXAM.—Sec-  
 11             tion 1861(nm)(2) (42 U.S.C. 1395x(nm)(2)) is  
 12             amended by striking “3 years” and inserting “2  
 13             years”.

14             (b) EFFECTIVE DATE.—The amendments made by  
 15     subsection (a) shall apply to items and services furnished  
 16     on or after January 1, 2001.

17     **SEC. 112. COVERAGE OF SCREENING COLONOSCOPY FOR**  
 18                     **AVERAGE RISK INDIVIDUALS.**

19             (a) IN GENERAL.—Section 1861(pp) (42 U.S.C.  
 20     1395x(pp)) is amended—

21                 (1) in paragraph (1)(C), by striking “In the  
 22             case of an individual at high risk for colorectal can-  
 23             cer, screening colonoscopy” and inserting “Screening  
 24             colonoscopy”; and

1 (2) in paragraph (2), by striking “In paragraph  
2 (1)(C), an” and inserting “An”.

3 (b) FREQUENCY LIMITS FOR SCREENING  
4 COLONOSCOPY.—Section 1834(d) (42 U.S.C. 1395m(d))  
5 is amended—

6 (1) in paragraph (2)(E)(ii), by inserting before  
7 the period at the end the following: “or, in the case  
8 of an individual who is not at high risk for colorectal  
9 cancer, if the procedure is performed within the 119  
10 months after a previous screening colonoscopy”;

11 (2) in paragraph (3)—

12 (A) in the heading by striking “FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CAN-  
13 CER”;  
14

15 (B) in subparagraph (A), by striking “for  
16 individuals at high risk for colorectal cancer (as  
17 defined in section 1861(pp)(2))”;

18 (C) in subparagraph (E), by inserting be-  
19 fore the period at the end the following: “or for  
20 other individuals if the procedure is performed  
21 within the 119 months after a previous screen-  
22 ing colonoscopy or within 47 months of a pre-  
23 vious screening flexible sigmoidoscopy”.

1 (c) EFFECTIVE DATE.—The amendments made by  
 2 this section apply to colorectal cancer screening services  
 3 provided on or after January 1, 2001.

4 **SEC. 113. MEDICAL NUTRITION THERAPY SERVICES FOR**  
 5 **BENEFICIARIES WITH DIABETES, A CARDIO-**  
 6 **VASCULAR DISEASE, OR A RENAL DISEASE.**

7 (a) COVERAGE.—Section 1861(s)(2) (42 U.S.C.  
 8 1395x(s)(2)) is amended—

9 (1) in subparagraph (S), by striking “and” at  
 10 the end;

11 (2) in subparagraph (T), by adding “and” at  
 12 the end; and

13 (3) by adding at the end the following new sub-  
 14 paragraph:

15 “(U) medical nutrition therapy services (as de-  
 16 fined in subsection (uu)(1)) in the case of a bene-  
 17 ficiary with diabetes, a cardiovascular disease (in-  
 18 cluding congestive heart failure, arteriosclerosis,  
 19 hyperlipidemia, hypertension, and  
 20 hypercholesterolemia), or a renal disease;”.

21 (b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C.  
 22 1395x) is amended by adding at the end the following new  
 23 subsection:



1       “Medical Nutrition Therapy Services; Registered  
2               Dietitian or Nutrition Professional

3       “(uu)(1) The term ‘medical nutrition therapy serv-  
4 ices’ means nutritional diagnostic, therapy, and counseling  
5 services for the purpose of disease management which are  
6 furnished by a registered dietitian or nutrition profes-  
7 sional (as defined in paragraph (2)) pursuant to a referral  
8 by a physician (as defined in subsection (r)(1)).

9       “(2) Subject to paragraph (3), the term ‘registered  
10 dietitian or nutrition professional’ means an individual  
11 who—

12               “(A) holds a baccalaureate or higher degree  
13 granted by a regionally accredited college or univer-  
14 sity in the United States (or an equivalent foreign  
15 degree) with completion of the academic require-  
16 ments of a program in nutrition or dietetics, as ac-  
17 credited by an appropriate national accreditation or-  
18 ganization recognized by the Secretary for this pur-  
19 pose;

20               “(B) has completed at least 900 hours of super-  
21 vised dietetics practice under the supervision of a  
22 registered dietitian or nutrition professional; and

23               “(C)(i) is licensed or certified as a dietitian or  
24 nutrition professional by the State in which the serv-  
25 ice is performed; or

1           “(ii) in the case of an individual in a State that  
 2           does not provide for such licensure or certification,  
 3           meets such other criteria as the Secretary estab-  
 4           lishes.

5           “(3) Subparagraphs (A) and (B) of paragraph (2)  
 6           shall not apply in the case of an individual who, as of the  
 7           date of enactment of this subsection, is licensed or cer-  
 8           tified as a dietitian or nutrition professional by the State  
 9           in which the medical nutrition therapy service is per-  
 10          formed.”.

11          (c) LIMITATION ON FREQUENCY.—Section 1834 (42  
 12          U.S.C. 1395m) is amended by adding at the end the fol-  
 13          lowing new subsection:

14          “(m) FREQUENCY LIMITATION FOR COVERAGE OF  
 15          MEDICAL NUTRITION THERAPY SERVICES.—Notwith-  
 16          standing any other provision of this part, no payment may  
 17          be made under this part for a medical nutrition therapy  
 18          service (as defined in section 1861(uu)) provided to an in-  
 19          dividual if such service is provided—

20                 “(1) during the 12-month period beginning on  
 21                 the date that such individual first received a medical  
 22                 nutrition therapy service covered under this part and  
 23                 such individual has previously received 3 medical nu-  
 24                 tritional therapy services during such period; or

1           “(2) at any time after such 12-month period if  
 2           such individual has previously received 3 medical nu-  
 3           tritional therapy services covered under this part  
 4           after such 12-month period.

5           (d) PAYMENT.—Section 1833(a)(1) (42 U.S.C.  
 6 1395l(a)(1)) is amended—

7           (1) by striking “and” before “(S)”; and

8           (2) by inserting before the semicolon at the end  
 9           the following: “, and (T) with respect to medical nu-  
 10          trition therapy services (as defined in section  
 11          1861(uu)(1)), the amount paid shall be 85 percent  
 12          of the lesser of the actual charge for the services  
 13          or the amount determined under the fee schedule es-  
 14          tablished under section 1848(b) for the same serv-  
 15          ices if furnished by a physician”.

16          (e) CONFORMING AMENDMENTS.—Section  
 17 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

18          (1) in subparagraph (H), by striking “and” at  
 19          the end;

20          (2) in subparagraph (I), by striking the semi-  
 21          colon at the end and inserting “, and”; and

22          (3) by adding at the end the following new sub-  
 23          paragraph:

24               “(J) in the case of medical nutrition therapy  
 25          services (as defined in section 1861(uu)(1)), which

1 are provided more frequently than is covered under  
 2 section 1834(m);”.

3 (f) EFFECTIVE DATE.—The amendments made by  
 4 this section apply to services furnished on or after July  
 5 1, 2001.

6 **SEC. 114. STATE ACCREDITATION OF DIABETES SELF-MAN-**  
 7 **AGEMENT TRAINING PROGRAMS.**

8 Section 1861(qq)(2) (42 U.S.C. 1395xx(qq)(2)) is  
 9 amended—

10 (1) in the matter preceding subparagraph (A),  
 11 by striking “paragraph (1)—” and inserting “para-  
 12 graph (1):”;

13 (2) in subparagraph (A)—

14 (A) by striking “a ‘certified provider’” and  
 15 inserting “A ‘certified provider’”; and

16 (B) by striking “; and” and inserting a pe-  
 17 riod; and

18 (3) in subparagraph (B)—

19 (A) by striking “a physician, or such other  
 20 individual” and inserting “(i) A physician, or  
 21 such other individual”;

22 (B) by inserting “(I)” before “meets appli-  
 23 cable standards”;

24 (C) by inserting “(II)” before “is recog-  
 25 nized”;

(D) by inserting “, or by a program described in clause (ii),” after “recognized by an organization that represents individuals (including individuals under this title) with diabetes”; and

(E) by adding at the end the following new clause:

“(ii) Notwithstanding any reference to ‘a national accreditation body’ in section 1865(b), for purposes of clause (i), a program described in this clause is a program operated by a State for the purposes of accrediting diabetes self-management training programs, if the Secretary determines that such State program has established quality standards that meet or exceed the standards established by the Secretary under clause (i) or the standards originally established by the National Diabetes Advisory Board and subsequently revised as described in clause (i).”.

**SEC. 115. STUDIES ON PREVENTIVE INTERVENTIONS IN  
PRIMARY CARE FOR OLDER AMERICANS.**

(a) STUDIES.—The Secretary of Health and Human Services, acting through the United States Preventive Services Task Force, shall conduct a series of studies designed to identify preventive interventions that can be de-

1 livered in the primary care setting and that are most valu-  
 2 able to older Americans.

3 (b) MISSION STATEMENT.—The mission statement of  
 4 the United States Preventive Services Task Force is  
 5 amended to include the evaluation of services that are of  
 6 particular relevance to older Americans.

7 (c) REPORT.—Not later than 1 year after the date  
 8 of enactment of this Act, and annually thereafter, the Sec-  
 9 retary of Health and Human Services shall submit a re-  
 10 port to Congress on the conclusions of the studies con-  
 11 ducted under subsection (a), together with recommenda-  
 12 tions for such legislation and administrative actions as the  
 13 Secretary considers appropriate.

14 **SEC. 116. INSTITUTE OF MEDICINE 3-YEAR MEDICARE PRE-**  
 15 **VENTION BENEFIT STUDY AND REPORT.**

16 (a) STUDY.—

17 (1) IN GENERAL.—The Secretary of Health and  
 18 Human Services shall contract with the Institute of  
 19 Medicine of the National Academy of Sciences—

20 (A) to conduct a comprehensive study of  
 21 current literature and best practices in the field  
 22 of health promotion and disease prevention  
 23 among medicare beneficiaries, including the  
 24 issues described in paragraph (2); and

1 (B) to submit the report described in sub-  
2 section (b).

3 (2) ISSUES STUDIED.—The study required  
4 under paragraph (1) shall include an assessment  
5 of—

6 (A) whether each covered benefit is—

7 (i) medically effective; and

8 (ii) a cost-effective benefit or a cost-  
9 saving benefit;

10 (B) utilization of covered benefits (includ-  
11 ing any barriers to or incentives to increase uti-  
12 lization); and

13 (C) quality of life issues associated with  
14 both health promotion and disease prevention  
15 benefits covered under the medicare program  
16 and those that are not covered under such pro-  
17 gram that would affect all medicare bene-  
18 ficiaries.

19 (b) REPORT.—

20 (1) IN GENERAL.—Not later than 3 years after  
21 the date of enactment of this Act, and every third  
22 year thereafter, the Institute of Medicine of the Na-  
23 tional Academy of Sciences shall submit to the Sec-  
24 retary of Health and Human Services and Congress  
25 a report that contains a detailed statement of the

1 findings and conclusions of the study conducted  
 2 under subsection (a) and the recommendations for  
 3 legislation described in paragraph (2).

4 (2) RECOMMENDATIONS FOR LEGISLATION.—  
 5 The Institute of Medicine of the National Academy  
 6 of Sciences, in consultation with the Partnership for  
 7 Prevention, shall develop recommendations in legis-  
 8 lative form that—

9 (A) prioritize the preventive benefits under  
 10 the medicare program; and

11 (B) modify preventive benefits offered  
 12 under the medicare program based on the study  
 13 conducted under subsection (a).

14 (3) REQUIREMENTS FOR INITIAL REPORT.—  
 15 The initial report submitted pursuant to paragraph  
 16 (1) shall address issues related to the following pre-  
 17 ventive benefits:

18 (A) Thyroid screening.

19 (B) Smoking cessation therapy services.

20 (C) Glaucoma detection tests.

21 (D) Appropriate preventive treatments for  
 22 precancerous skin lesions.

23 (c) DEFINITIONS.—In this section:



1           (1) COST-EFFECTIVE BENEFIT.—The term  
 2           “cost-effective benefit” means a benefit or technique  
 3           that has—

4                   (A) been subject to peer review;  
 5                   (B) been described in scientific journals;  
 6           and  
 7                   (C) demonstrated value as measured by  
 8           unit costs relative to health outcomes achieved.

9           (2) COST-SAVING BENEFIT.—The term “cost-  
 10          saving benefit” means a benefit or technique that  
 11          has—

12                   (A) been subject to peer review;  
 13                   (B) been described in scientific journals;  
 14          and  
 15                   (C) caused a net reduction in health care  
 16          costs for medicare beneficiaries.

17          (3) MEDICALLY EFFECTIVE.—The term “medi-  
 18          cally effective” means, with respect to a benefit or  
 19          technique, that the benefit or technique has been—

20                   (A) subject to peer review;  
 21                   (B) described in scientific journals; and  
 22                   (C) determined to achieve an intended goal  
 23          under normal programmatic conditions.

24          (4) MEDICARE BENEFICIARY.—The term  
 25          “medicare beneficiary” means any individual who is

1 entitled to benefits under part A or enrolled under  
 2 part B of the medicare program under title XVIII  
 3 of the Social Security Act, including any individual  
 4 enrolled in a Medicare+Choice plan offered by a  
 5 Medicare+Choice organization under part C of such  
 6 program.

7 **SEC. 117. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
 8 **ERAGE OF CARDIAC AND PULMONARY REHA-**  
 9 **BILITATION THERAPY SERVICES.**

10 (a) STUDY.—

11 (1) IN GENERAL.—The Medicare Payment Ad-  
 12 visory Commission established under section 1805 of  
 13 the Social Security Act (42 U.S.C. 1395b–6) (in this  
 14 section referred to as “MedPAC”) shall conduct a  
 15 study on coverage of cardiac and pulmonary rehabili-  
 16 tation therapy services under the medicare program  
 17 under title XVIII of the Social Security Act (42  
 18 U.S.C. 1395 et seq.).

19 (2) FOCUS.—In conducting the study under  
 20 paragraph (1), MedPAC shall focus on the  
 21 appropriate—

22 (A) qualifying diagnoses required for cov-  
 23 erage of cardiac and pulmonary rehabilitation  
 24 therapy services;

1 (B) level of physician direct involvement  
 2 and supervision in furnishing such services; and  
 3 (C) level of reimbursement for such serv-  
 4 ices.

5 (b) REPORT.—Not later than 18 months after the  
 6 date of enactment of this Act, MedPAC shall submit a  
 7 report to the Secretary of Health and Human Services and  
 8 Congress on the study conducted under subsection (a) to-  
 9 gether with such recommendations for legislation and ad-  
 10 ministrative action as MedPAC determines appropriate.

11 **TITLE II—RURAL HEALTH CARE**  
 12 **IMPROVEMENTS**  
 13 **Subtitle A—Critical Access**  
 14 **Hospital Provisions**

15 **SEC. 201. CLARIFICATION OF NO BENEFICIARY COST-SHAR-**  
 16 **ING FOR CLINICAL DIAGNOSTIC LABORA-**  
 17 **TORY TESTS FURNISHED BY CRITICAL AC-**  
 18 **CESS HOSPITALS.**

19 (a) PAYMENT CLARIFICATION.—Section 1834(g) (42  
 20 U.S.C. 1395m(g)) is amended by adding at the end the  
 21 following new paragraph:

22 “(4) NO BENEFICIARY COST-SHARING FOR  
 23 CLINICAL DIAGNOSTIC LABORATORY SERVICES.—No  
 24 coinsurance, deductible, copayment, or other cost  
 25 sharing otherwise applicable under this part shall

1       apply with respect to clinical diagnostic laboratory  
 2       services furnished as an outpatient critical access  
 3       hospital service. Nothing in this title shall be con-  
 4       strued as providing for payment for clinical diag-  
 5       nostic laboratory services furnished as part of out-  
 6       patient critical access hospital services, other than  
 7       on the basis described in this subsection.”.

8       (b) TECHNICAL AND CONFORMING AMENDMENTS.—

9           (1) Paragraphs (1)(D)(i) and (2)(D)(i) of sec-  
 10       tion 1833(a) (42 U.S.C. 1395l(a)(1)(D)(i);  
 11       1395l(a)(2)(D)(i)) are each amended by striking “or  
 12       which are furnished on an outpatient basis by a crit-  
 13       ical access hospital”.

14          (2) Section 403(d)(2) of BBRA (113 Stat.  
 15       1501A–371) is amended by striking “The amend-  
 16       ment made by subsection (a) shall apply” and in-  
 17       serting “Paragraphs (1) through (3) of section  
 18       1834(g) of the Social Security Act (as amended by  
 19       paragraph (1)) apply”.

20       (c) EFFECTIVE DATES.—The amendment made—

21           (1) by subsection (a) applies to services fur-  
 22       nished on or after the date of the enactment of  
 23       BBRA;

1           (2) by subsection (b)(1) applies as if included  
 2           in the enactment of section 403(e)(1) of BBRA (113  
 3           Stat. 1501A–371); and

4           (3) by subsection (b)(2) applies as if included  
 5           in the enactment of section 403(d)(2) of BBRA  
 6           (113 Stat. 1501A–371).

7   **SEC. 202. REVISION OF PAYMENT FOR PROFESSIONAL**  
 8                           **SERVICES PROVIDED BY A CRITICAL ACCESS**  
 9                           **HOSPITAL.**

10          (a) IN GENERAL.—Section 1834(g)(2)(B) (42 U.S.C.  
 11   1395m(g)(2)(B)), as amended by section 403(d) of BBRA  
 12   (113 Stat. 1501A–371), is amended by inserting “120  
 13   percent of” after “hospital services,”.

14          (b) EFFECTIVE DATE.—The amendment made by  
 15   subsection (a) shall take effect as if included in the enact-  
 16   ment of section 403(d) of BBRA (113 Stat. 1501A–371).

17   **SEC. 203. PERMITTING CRITICAL ACCESS HOSPITALS TO**  
 18                           **OPERATE PPS EXEMPT DISTINCT PART PSY-**  
 19                           **CHIATRIC AND REHABILITATION UNITS.**

20          (a) CRITERIA FOR DESIGNATION AS A CRITICAL AC-  
 21   CESS HOSPITAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C.  
 22   1395i–4(c)(2)(B)(iii)) is amended by inserting “excluding  
 23   any psychiatric or rehabilitation unit of the facility which  
 24   is a distinct part of the facility,” before “provides not”.

1 (b) DEFINITION OF PPS EXEMPT DISTINCT PART  
 2 PSYCHIATRIC AND REHABILITATION UNITS.—Section  
 3 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended  
 4 by inserting before the last sentence the following new sen-  
 5 tence: “In establishing such definition, the Secretary may  
 6 not exclude from such definition a psychiatric or rehabili-  
 7 tation unit of a critical access hospital which is a distinct  
 8 part of such hospital solely because such hospital is ex-  
 9 empt from the prospective payment system under this sec-  
 10 tion.”.

11 (c) EFFECTIVE DATE.—The amendments made by  
 12 this section shall take effect on the date of enactment of  
 13 this Act.

14 **SEC. 204. EXEMPTION OF CRITICAL ACCESS HOSPITAL**  
 15 **SWING BEDS FROM SNF PPS.**

16 (a) IN GENERAL.—Section 1888(e)(7) Act (42  
 17 U.S.C. 1395yy(e)(7)) is amended—

18 (1) in the heading, by striking “TRANSITION  
 19 FOR” and inserting “TREATMENT OF”;

20 (2) in subparagraph (A), by striking “IN GEN-  
 21 ERAL.—The” and inserting “TRANSITION.—Subject  
 22 to subparagraph (C), the”;

23 (3) in subparagraph (A), by inserting “(other  
 24 than critical access hospitals)” after “facilities de-  
 25 scribed in subparagraph (B)”;

1           (4) in subparagraph (B), by striking “, for  
2       which payment” and all that follows before the pe-  
3       riod at the end; and

4           (5) by adding at the end the following new sub-  
5       paragraph:

6                       “(C) EXEMPTION FROM PPS OF SWING-  
7       BED SERVICES FURNISHED IN CRITICAL ACCESS  
8       HOSPITALS.—The prospective payment system  
9       established under this subsection shall not  
10      apply to services furnished by a critical access  
11      hospital pursuant to an agreement under sec-  
12      tion 1883.”.

13       (b) PAYMENT ON A REASONABLE COST BASIS FOR  
14   SWING BED SERVICES FURNISHED BY CRITICAL ACCESS  
15   HOSPITALS.—Section 1883(a) (42 U.S.C 1395tt(a)) is  
16   amended—

17           (1) in paragraph (2)(A), by inserting “(other  
18      than a critical access hospital)” after “any hospital”;  
19      and

20           (2) by adding at the end the following new  
21      paragraph:

22                       “(3) Notwithstanding any other provision of  
23      this title, a critical access hospital shall be paid for  
24      covered skilled nursing facility services furnished  
25      under an agreement entered into under this section

1 on the basis of the reasonable costs of such services  
 2 (as determined under section 1861(v)).”.

3 (c) EFFECTIVE DATE.—The amendments made by  
 4 this section shall apply to cost reporting periods beginning  
 5 on or after the date of the enactment of this Act.

## 6 **Subtitle B—Other Rural Hospital** 7 **Provisions**

### 8 **SEC. 211. EQUITABLE TREATMENT FOR RURAL DISPROPOR-** 9 **TIONATE SHARE HOSPITALS.**

10 (a) APPLICATION OF UNIFORM THRESHOLD.—Sec-  
 11 tion 1886(d)(5)(F)(v) (42 U.S.C. 1395ww(d)(5)(F)(v)) is  
 12 amended—

13 (1) in subclause (II), by inserting “(or 15 per-  
 14 cent, for discharges occurring on or after October 1,  
 15 2001)” after “30 percent”;

16 (2) in subclause (III), by inserting “(or 15 per-  
 17 cent, for discharges occurring on or after October 1,  
 18 2001)” after “40 percent”; and

19 (3) in subclause (IV), by inserting “(or 15 per-  
 20 cent, for discharges occurring on or after October 1,  
 21 2001)” after “45 percent”.

22 (b) ADJUSTMENT OF PAYMENT FORMULAS.—

23 (1) SOLE COMMUNITY HOSPITALS.—Section  
 24 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is  
 25 amended—



1 (A) in clause (iv)(VI), by inserting after  
 2 “10 percent” the following: “or, for discharges  
 3 occurring on or after October 1, 2001, is equal  
 4 to the percent determined in accordance with  
 5 clause (x)”; and

6 (B) by adding at the end the following new  
 7 clause:

8 “(x) For purposes of clause (iv)(VI), in the case of  
 9 a hospital for a cost reporting period with a dispropor-  
 10 tionate patient percentage (as defined in clause (vi))  
 11 that—

12 “(I) is less than 17.3, the disproportionate  
 13 share adjustment percentage is determined in ac-  
 14 cordance with the following formula:  $(P-15)(.65) +$   
 15  $2.5$ ;

16 “(II) is equal to or exceeds 17.3, but is less  
 17 than 30.0, such adjustment percentage is equal to 4  
 18 percent; or

19 “(III) is equal to or exceeds 30, such adjust-  
 20 ment percentage is equal to 10 percent,

21 where ‘P’ is the hospital’s disproportionate patient per-  
 22 centage (as defined in clause (vi)).”.

23 (2) RURAL REFERRAL CENTERS.—Such section  
 24 is further amended—

1 (A) in clause (iv)(V), by inserting after  
 2 “clause (viii)” the following: “or, for discharges  
 3 occurring on or after October 1, 2001, is equal  
 4 to the percent determined in accordance with  
 5 clause (xi)”;

6 (B) by adding at the end the following new  
 7 clause:

8 “(xi) For purposes of clause (iv)(V), in the case of  
 9 a hospital for a cost reporting period with a dispropor-  
 10 tionate patient percentage (as defined in clause (vi))  
 11 that—

12 “(I) is less than 17.3, the disproportionate  
 13 share adjustment percentage is determined in ac-  
 14 cordance with the following formula:  $(P-15)(.65) +$   
 15  $2.5$ ;

16 “(II) is equal to or exceeds 17.3, but is less  
 17 than 30.0, such adjustment percentage is equal to 4  
 18 percent; or

19 “(III) is equal to or exceeds 30, such adjust-  
 20 ment percentage is determined in accordance with  
 21 the following formula:  $(P-30)(.6) + 4$ ,

22 where ‘P’ is the hospital’s disproportionate patient per-  
 23 centage (as defined in clause (vi)).”.

24 (3) SMALL RURAL HOSPITALS GENERALLY.—

25 Such section is further amended—

1 (A) in clause (iv)(III), by inserting after  
 2 “4 percent” the following: “or, for discharges  
 3 occurring on or after October 1, 2001, is equal  
 4 to the percent determined in accordance with  
 5 clause (xii)”;

6 (B) by adding at the end the following new  
 7 clause:

8 “(xii) For purposes of clause (iv)(III), in the case of  
 9 a hospital for a cost reporting period with a dispropor-  
 10 tionate patient percentage (as defined in clause (vi))  
 11 that—

12 “(I) is less than 17.3, the disproportionate  
 13 share adjustment percentage is determined in ac-  
 14 cordance with the following formula:  $(P-15)(.65) +$   
 15  $2.5$ ;

16 “(II) is equal to or exceeds 17.3, such adjust-  
 17 ment percentage is equal to 4 percent,  
 18 where ‘P’ is the hospital’s disproportionate patient per-  
 19 centage (as defined in clause (vi)).”.

20 (4) HOSPITALS THAT ARE BOTH SOLE COMMU-  
 21 NITY HOSPITALS AND RURAL REFERRAL CENTERS.—  
 22 Such section is further amended, in clause (iv)(IV),  
 23 by inserting after “clause (viii)” the following: “or,  
 24 for discharges occurring on or after October 1,

1       2001, the greater of the percentages determined  
2       under clause (x) or (xi)”.

3               (5) URBAN HOSPITALS WITH LESS THAN 100  
4       BEDS.—Such section is further amended—

5               (A) in clause (iv)(II), by inserting after “5  
6       percent” the following: “or, for discharges oc-  
7       curring on or after October 1, 2001, is equal to  
8       the percent determined in accordance with  
9       clause (xiii)”;

10              (B) by adding at the end the following new  
11       clause:

12       “(xiii) For purposes of clause (iv)(II), in the case of  
13       a hospital for a cost reporting period with a dispropor-  
14       tionate patient percentage (as defined in clause (vi))  
15       that—

16              “(I) is less than 17.3, the disproportionate  
17       share adjustment percentage is determined in ac-  
18       cordance with the following formula:  $(P-15)(.65) +$   
19       2.5;

20              “(II) is equal to or exceeds 17.3, but is less  
21       than 40.0, such adjustment percentage is equal to 4  
22       percent; or

23              “(III) is equal to or exceeds 40, such adjust-  
24       ment percentage is equal to 5 percent,

1 where ‘P’ is the hospital’s disproportionate patient per-  
 2 centage (as defined in clause (vi)).”.

3 (c) TECHNICAL AMENDMENT.—Section  
 4 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) is  
 5 amended by striking “and before October 1, 1997,”.

6 **SEC. 212. OPTION TO BASE ELIGIBILITY FOR MEDICARE DE-**  
 7 **PENDENT, SMALL RURAL HOSPITAL PRO-**  
 8 **GRAM ON DISCHARGES DURING ANY OF THE**  
 9 **3 MOST RECENT AUDITED COST REPORTING**  
 10 **PERIODS.**

11 (a) IN GENERAL.—Section 1886(d)(5)(G)(iv)(IV)  
 12 (42 U.S.C. 1395ww(d)(5)(G)(iv)(IV)) is amended by in-  
 13 serting “, or any of the 3 most recent audited cost report-  
 14 ing periods,” after “1987”.

15 (b) EFFECTIVE DATE.—The amendment made by  
 16 this section shall apply with respect to cost reporting peri-  
 17 ods beginning on or after the date of enactment of this  
 18 Act.

19 **SEC. 213. EXTENSION OF OPTION TO USE REBASED TARGET**  
 20 **AMOUNTS TO ALL SOLE COMMUNITY HOS-**  
 21 **PITALS.**

22 (a) IN GENERAL.—Section 1886(b)(3)(I)(i) (42  
 23 U.S.C. 1395ww(b)(3)(I)(i)) is amended—

24 (1) in the matter preceding subclause (I)—

1 (A) by striking “that for its cost reporting  
 2 period beginning during 1999 is paid on the  
 3 basis of the target amount applicable to the  
 4 hospital under subparagraph (C) and that  
 5 elects (in a form and manner determined by the  
 6 Secretary) this subparagraph to apply to the  
 7 hospital”; and

8 (B) by striking “substituted for such tar-  
 9 get amount” and inserting “substituted, if such  
 10 substitution results in a greater payment under  
 11 this section for such hospital, for the amount  
 12 otherwise determined under subsection  
 13 (d)(5)(D)(i)”; and

14 (2) in subclause (I), by striking “target amount  
 15 otherwise applicable” and all that follows through  
 16 “target amount’”)” and inserting “the amount other-  
 17 wise applicable to the hospital under subsection  
 18 (d)(5)(D)(i) (referred to in this clause as the ‘sub-  
 19 section (d)(5)(D)(i) amount’)”; and

20 (3) in each of subclauses (II) and (III), by  
 21 striking “subparagraph (C) target amount” and in-  
 22 serting “subsection (d)(5)(D)(i) amount”.

23 (b) EFFECTIVE DATE.—The amendments made by  
 24 this section shall take effect as if included in the enact-  
 25 ment of section 405 of BBRA (113 Stat. 1501A–372).

1 **SEC. 214. MEDPAC ANALYSIS OF IMPACT OF VOLUME ON**  
 2 **PER UNIT COST OF RURAL HOSPITALS WITH**  
 3 **PSYCHIATRIC UNITS.**

4 The Medicare Payment Advisory Commission, in its  
 5 study conducted pursuant to subsection (a) of section 411  
 6 of BBRA (113 Stat. 1501A–377), shall include—

7 (1) in such study an analysis of the impact of  
 8 volume on the per unit cost of rural hospitals with  
 9 psychiatric units; and

10 (2) in its report under subsection (b) of such  
 11 section a recommendation on whether special treat-  
 12 ment for such hospitals may be warranted.

13 **Subtitle C—Other Rural Provisions**

14 **SEC. 221. PROVIDER-BASED RURAL HEALTH CLINIC CAP**  
 15 **EXEMPTION.**

16 (a) IN GENERAL.—The matter in section 1833(f) (42  
 17 U.S.C. 1395l(f)) preceding paragraph (1) is amended by  
 18 striking “with less than 50 beds” and inserting “with an  
 19 average daily patient census that does not exceed 50”.

20 (b) EFFECTIVE DATE.—The amendment made by  
 21 subparagraph (A) shall apply to services furnished on or  
 22 after January 1, 2001.

23 **SEC. 222. PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT**  
 24 **SERVICES.**

25 (a) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT  
 26 SERVICES.—Section 1842(b)(6)(C) (42 U.S.C.

1 1395u(b)(6)(C)) is amended by striking “for such services  
2 provided before January 1, 2003,”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) shall take effect on the date of enactment  
5 of this Act.

6 **SEC. 223. TEMPORARY INCREASE FOR HOME HEALTH**  
7 **SERVICES FURNISHED IN A RURAL AREA.**

8 (a) INCREASE FOR 2001 AND 2002.—In the case of  
9 a unit of home health service furnished in a rural area  
10 (as defined in section 1886(d)(2)(D) of the Social Security  
11 Act (42 U.S.C. 1395ww(d)(2)(D))) during 2001 or 2002,  
12 the Secretary of Health and Human Services (in this sec-  
13 tion referred to as the “Secretary”) shall increase the pay-  
14 ment amount otherwise made under section 1895 of such  
15 Act (42 U.S.C. 1395fff) for such unit of service by 10  
16 percent.

17 (b) ADDITIONAL PAYMENT NOT BUILT INTO THE  
18 BASE.—The Secretary shall not include any additional  
19 payment made under subsection (a) in updating the stand-  
20 ard prospective payment amount (or amounts) applicable  
21 to units of home health services furnished during a period,  
22 as increased by the home health applicable increase per-  
23 centage for the fiscal year involved under section  
24 1895(b)(3)(B) of the Social Security Act (42 U.S.C.  
25 1395fff(b)(3)(B)).



1       (c) WAIVING BUDGET NEUTRALITY.—The Secretary  
 2 shall not reduce the standard prospective payment amount  
 3 (or amounts) under section 1895 of the Social Security  
 4 Act (42 U.S.C. 1395fff) applicable to units of home health  
 5 services furnished during a period to offset the increase  
 6 in payments resulting from the application of subsection  
 7 (a).

8   **SEC. 224. REFINEMENT OF MEDICARE REIMBURSEMENT**  
 9                   **FOR TELEHEALTH SERVICES.**

10       (a) REVISION OF TELEHEALTH PAYMENT METHOD-  
 11 OLOGY AND ELIMINATION OF FEE-SHARING REQUIRE-  
 12 MENT.—Section 4206(b) of the Balanced Budget Act of  
 13 1997 (42 U.S.C. 1395l note) is amended to read as fol-  
 14 lows:

15       “(b) METHODOLOGY FOR DETERMINING AMOUNT OF  
 16 PAYMENTS.—

17               “(1) IN GENERAL.—The Secretary shall pay  
 18       to—

19                   “(A) the physician or practitioner at a dis-  
 20 tant site that provides an item or service under  
 21 subsection (a) an amount equal to the amount  
 22 that such physician or provider would have been  
 23 paid had the item or service been provided with-  
 24 out the use of a telecommunications system;  
 25       and

1           “(B) the originating site a facility fee for  
2           facility services furnished in connection with  
3           such item or service.

4           “(2) APPLICATION OF PART B COINSURANCE  
5           AND DEDUCTIBLE.—Any payment made under this  
6           section shall be subject to the coinsurance and de-  
7           ductible requirements under subsections (a)(1) and  
8           (b) of section 1833 of the Social Security Act (42  
9           U.S.C. 1395l).

10          “(3) DEFINITIONS.—In this subsection:

11           “(A) DISTANT SITE.—The term ‘distant  
12           site’ means the site at which the physician or  
13           practitioner is located at the time the item or  
14           service is provided via a telecommunications  
15           system.

16           “(B) FACILITY FEE.—The term ‘facility  
17           fee’ means an amount equal to—

18                   “(i) for 2000 and 2001, \$20; and

19                   “(ii) for a subsequent year, the facil-  
20           ity fee under this subsection for the pre-  
21           vious year increased by the percentage in-  
22           crease in the MEI (as defined in section  
23           1842(i)(3)) for such subsequent year.

24           “(C) ORIGINATING SITE.—

1 “(i) IN GENERAL.—The term ‘origi-  
 2 nating site’ means the site described in  
 3 clause (ii) at which the eligible telehealth  
 4 beneficiary under the medicare program is  
 5 located at the time the item or service is  
 6 provided via a telecommunications system.

7 “(ii) SITES DESCRIBED.—The sites  
 8 described in this paragraph are as follows:

9 “(I) On or before January 1,  
 10 2002, the office of a physician or a  
 11 practitioner, a critical access hospital,  
 12 a rural health clinic, and a Federally  
 13 qualified health center.

14 “(II) On or before January 1,  
 15 2003, a hospital, a skilled nursing fa-  
 16 cility, a comprehensive outpatient re-  
 17 habilitation facility, a renal dialysis  
 18 facility, an ambulatory surgical center,  
 19 an Indian Health Service facility, and  
 20 a community mental health center.”.

21 (b) ELIMINATION OF REQUIREMENT FOR TELEPRE-  
 22 SENTER.—Section 4206 of the Balanced Budget Act of  
 23 1997 (42 U.S.C. 1395l note) is amended—

1           (1) in subsection (a), by striking “, notwith-  
 2           standing that the individual physician” and all that  
 3           follows before the period at the end; and

4           (2) by adding at the end the following new sub-  
 5           section:

6           “(e) TELEPRESENTER NOT REQUIRED.—Nothing in  
 7           this section shall be construed as requiring an eligible tele-  
 8           health beneficiary to be presented by a physician or practi-  
 9           tioner for the provision of an item or service via a tele-  
 10          communications system.”.

11          (c) REIMBURSEMENT FOR MEDICARE BENE-  
 12          FICIARIES WHO DO NOT RESIDE IN A HPSA.—Section  
 13          4206(a) of the Balanced Budget Act of 1997 (42 U.S.C.  
 14          1395l note), as amended by subsection (b), is amended—

15               (1) by striking “IN GENERAL.—Not later than”  
 16               and inserting the following: “TELEHEALTH SERV-  
 17               ICES REIMBURSED.—

18               “(1) IN GENERAL.—Not later than”;

19               (2) by striking “furnishing a service for which  
 20               payment” and all that follows before the period and  
 21               inserting “to an eligible telehealth beneficiary”; and

22               (3) by adding at the end the following new  
 23               paragraph:

24               “(2) ELIGIBLE TELEHEALTH BENEFICIARY DE-  
 25               FINED.—In this section, the term ‘eligible telehealth

1 beneficiary’ means a beneficiary under the medicare  
 2 program under title XVIII of the Social Security Act  
 3 (42 U.S.C. 1395 et seq.) that resides in—

4 “(A) an area that is designated as a health  
 5 professional shortage area under section  
 6 332(a)(1)(A) of the Public Health Service Act  
 7 (42 U.S.C. 254e(a)(1)(A));

8 “(B) a county that is not included in a  
 9 Metropolitan Statistical Area; or

10 “(C) an inner-city area that is medically  
 11 underserved (as defined in section 330(b)(3) of  
 12 the Public Health Service Act (42 U.S.C.  
 13 254b(b)(3))).”.

14 (d) TELEHEALTH COVERAGE FOR DIRECT PATIENT  
 15 CARE.—

16 (1) IN GENERAL.—Section 4206 of the Bal-  
 17 anced Budget Act of 1997 (42 U.S.C. 1395l note),  
 18 as amended by subsection (c), is amended—

19 (A) in subsection (a)(1), by striking “pro-  
 20 fessional consultation via telecommunications  
 21 systems with a physician” and inserting “items  
 22 and services for which payment may be made  
 23 under such part that are furnished via a tele-  
 24 communications system by a physician”; and

1 (B) by adding at the end the following new  
2 subsection:

3 “(f) COVERAGE OF ITEMS AND SERVICES.—Payment  
4 for items and services provided pursuant to subsection (a)  
5 shall include payment for professional consultations, office  
6 visits, office psychiatry services, including any service  
7 identified as of July 1, 2000, by HCPCS codes 99241–  
8 99275, 99201–99215, 90804–90815, and 90862.”.

9 (2) STUDY AND REPORT REGARDING ADDI-  
10 TIONAL ITEMS AND SERVICES.—

11 (A) STUDY.—The Secretary of Health and  
12 Human Services shall conduct a study to iden-  
13 tify items and services in addition to those de-  
14 scribed in section 4206(f) of the Balanced  
15 Budget Act of 1997 (as added by paragraph  
16 (1)) that would be appropriate to provide pay-  
17 ment under title XVIII of the Social Security  
18 Act (42 U.S.C. 1395 et seq.).

19 (B) REPORT.—Not later than 2 years after  
20 the date of enactment of this Act, the Secretary  
21 shall submit a report to Congress on the study  
22 conducted under subparagraph (A) together  
23 with such recommendations for legislation that  
24 the Secretary determines are appropriate.

1 (e) ALL PHYSICIANS AND PRACTITIONERS ELIGIBLE  
 2 FOR TELEHEALTH REIMBURSEMENT.—Section 4206(a)  
 3 of the Balanced Budget Act of 1997 (42 U.S.C. 1395l  
 4 note), as amended by subsection (d), is amended—

5 (1) in paragraph (1), by striking “(described in  
 6 section 1842(b)(18)(C) of such Act (42 U.S.C.  
 7 1395u(b)(18)(C))”; and

8 (2) by adding at the end the following new  
 9 paragraph:

10 “(3) PRACTITIONER DEFINED.—For purposes  
 11 of paragraph (1), the term ‘practitioner’ includes—

12 “(A) a practitioner described in section  
 13 1842(b)(18)(C) of the Social Security Act (42  
 14 U.S.C. 1395u(b)(18)(C)); and

15 “(B) a physical, occupational, or speech  
 16 therapist.”.

17 (f) TELEHEALTH SERVICES PROVIDED USING  
 18 STORE-AND-FORWARD TECHNOLOGIES.—Section  
 19 4206(a)(1) of the Balanced Budget Act of 1997 (42  
 20 U.S.C. 1395l note), as amended by subsection (e), is  
 21 amended by adding at the end the following new para-  
 22 graph:

23 “(4) USE OF STORE-AND-FORWARD TECH-  
 24 NOLOGIES.—For purposes of paragraph (1), in the  
 25 case of any Federal telemedicine demonstration pro-

1       gram in Alaska or Hawaii, the term ‘telecommuni-  
 2       cations system’ includes store-and-forward tech-  
 3       nologies that provide for the asynchronous trans-  
 4       mission of health care information in single or multi-  
 5       media formats.”.

6       (g) CONSTRUCTION RELATING TO HOME HEALTH  
 7 SERVICES.—Section 4206(a) of the Balanced Budget Act  
 8 of 1997 (42 U.S.C. 1395l note), as amended by subsection  
 9 (f), is amended by adding at the end the following new  
 10 paragraph:

11               “(5) CONSTRUCTION RELATING TO HOME  
 12 HEALTH SERVICES.—

13               “(A) IN GENERAL.—Nothing in this sec-  
 14 tion or in section 1895 of the Social Security  
 15 Act (42 U.S.C. 1395fff) shall be construed as  
 16 preventing a home health agency that is receiv-  
 17 ing payment under the prospective payment  
 18 system described in such section from fur-  
 19 nishing a home health service via a tele-  
 20 communications system.

21               “(B) LIMITATION.—The Secretary shall  
 22 not consider a home health service provided in  
 23 the manner described in subparagraph (A) to  
 24 be a home health visit for purposes of—



1 “(i) determining the amount of pay-  
 2 ment to be made under the prospective  
 3 payment system established under section  
 4 1895 of the Social Security Act (42 U.S.C.  
 5 1395fff); or

6 “(ii) any requirement relating to the  
 7 certification of a physician required under  
 8 section 1814(a)(2)(C) of such Act (42  
 9 U.S.C. 1395f(a)(2)(C)).”.

10 (h) FIVE-YEAR APPLICATION.—The amendments  
 11 made by this section shall apply to items and services pro-  
 12 vided on or after April 1, 2001, and before April 1, 2006.

13 **SEC. 225. MEDPAC STUDY ON LOW-VOLUME, ISOLATED**  
 14 **RURAL HEALTH CARE PROVIDERS.**

15 (a) STUDY.—The Medicare Payment Advisory Com-  
 16 mission established under section 1805 of the Social Secu-  
 17 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
 18 as “MedPAC”) shall conduct a study on the effect of low  
 19 patient and procedure volume on the financial status of  
 20 low-volume, isolated rural health care providers partici-  
 21 pating in the medicare program under title XVIII of the  
 22 Social Security Act (42 U.S.C. 1395 et seq.).

23 (b) REPORT.—Not later than 18 months after the  
 24 date of enactment of this Act, MedPAC shall submit a  
 25 report to the Secretary of Health and Human Services and

1 Congress on the study conducted under subsection (a)  
2 indicating—

3           (1) whether low-volume, isolated rural health  
4       care providers are having, or may have, significantly  
5       decreased medicare margins or other financial dif-  
6       ficulties resulting from any of the payment meth-  
7       odologies described in subsection (c);

8           (2) whether the status as a low-volume, isolated  
9       rural health care provider should be designated  
10      under the medicare program and any criteria that  
11      should be used to qualify for such a status; and

12          (3) any changes in the payment methodologies  
13      described in subsection (c) that are necessary to pro-  
14      vide appropriate reimbursement under the medicare  
15      program to low-volume, isolated rural health care  
16      providers (as designated pursuant to paragraph (2)).

17      (c) PAYMENT METHODOLOGIES DESCRIBED.—The  
18      payment methodologies described in this subsection are  
19      the following:

20          (1) The prospective payment system for hos-  
21      pital outpatient department services under section  
22      1833(t) of the Social Security Act (42 U.S.C.  
23      1395l).

1           (2) The fee schedule for ambulance services  
 2           under section 1834(l) of such Act (42 U.S.C.  
 3           1395m(l)).

4           (3) The prospective payment system for inpa-  
 5           tient hospital services under section 1886 of such  
 6           Act (42 U.S.C. 1395ww).

7           (4) The prospective payment system for routine  
 8           service costs of skilled nursing facilities under sec-  
 9           tion 1888(e) of such Act (42 U.S.C. 1395yy(e)).

10          (5) The prospective payment system for home  
 11          health services under section 1895 of such Act (42  
 12          U.S.C. 1395fff).

13                   **TITLE III—PROVISIONS**  
 14                   **RELATING TO PART A**  
 15                   **Subtitle A—PPS Hospitals**

16   **SEC. 301. DELAY OF REDUCTION IN PPS HOSPITAL PAY-**  
 17                   **MENT UPDATE.**

18          (a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42  
 19          U.S.C. 1395ww(b)(3)(B)(i)) is amended—

20               (1) in subclause (XVI), by striking “minus 1.1  
 21               percentage points for hospitals (other than sole com-  
 22               munity hospitals) in all areas, and the market bas-  
 23               ket percentage increase for sole community hos-  
 24               pitals,” and inserting “for hospitals in all areas,”;

25               (2) in subclause (XVII)—

1 (A) by striking “minus 1.1 percentage  
2 points”; and

3 (B) by striking “and” at the end;

4 (3) by redesignating subclause (XVIII) as sub-  
5 clause (XIX);

6 (4) in subclause (XIX), as so redesignated, by  
7 striking “fiscal year 2003” and inserting “fiscal year  
8 2004”; and

9 (5) by inserting after subclause (XVII) the fol-  
10 lowing new subclause:

11 “(XVIII) for fiscal year 2003, the market bas-  
12 ket percentage increase minus 1 percentage point for  
13 hospitals in all areas, and”.

14 (b) SPECIAL RULE FOR PAYMENT FOR INPATIENT  
15 HOSPITAL SERVICES FOR FISCAL YEAR 2001.—Notwith-  
16 standing the amendments made by subsection (a), for pur-  
17 poses of making payments for fiscal year 2001 for inpa-  
18 tient hospital services furnished by subsection (d) hos-  
19 pitals (as defined in section 1886(d)(1)(B) of the Social  
20 Security Act (42 U.S.C. 1395ww(d)(1)(B))), the “applica-  
21 ble percentage increase” referred to in section  
22 1886(b)(3)(B)(i) of such Act (42 U.S.C.  
23 1395ww(b)(3)(B)(i))—

24 (1) for discharges occurring on or after October  
25 1, 2000, and before April 1, 2001, shall be deter-

1       mined in accordance with subclause (XVI) of such  
 2       section as in effect on the day before the date of en-  
 3       actment of this Act; and

4               (2) for discharges occurring on or after April 1,  
 5       2001, and before October 1, 2001, shall be equal  
 6       to—

7               (A) the market basket percentage increase  
 8       plus 1.1 percentage points for hospitals (other  
 9       than sole community hospitals) in all areas; and

10              (B) the market basket percentage increase  
 11       for sole community hospitals.

12 **SEC. 302. REVISION OF REDUCTION OF INDIRECT GRAD-**  
 13 **UATE MEDICAL EDUCATION PAYMENTS.**

14       (a) REVISION.—Section 1886(d)(5)(B)(ii) (42 U.S.C.  
 15 1395ww(d)(5)(B)(ii)) is amended—

16              (1) in subclause (V)—

17                (A) by striking “fiscal year 2001” and in-  
 18       serting “each of fiscal years 2001 and 2002”;  
 19       and

20                (B) by striking “equal to 1.54” and insert-  
 21       ing “equal to 1.6”; and

22              (2) in subclause (VI), by striking “2001” and  
 23       inserting “2002”.

24       (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 25 2001.—Notwithstanding paragraph (5)(B)(ii)(V) of sec-

tion 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)(V)) (as amended by subsection (a)), for purposes of making payments for fiscal year 2001 for subsection (d) hospitals (as defined in paragraph (1)(B) of such section) with indirect costs of medical education, the indirect teaching adjustment factor referred to in paragraph (5)(B)(ii) of such section shall be determined—

(1) for discharges occurring on or after October 1, 2000, and before April 1, 2001, in accordance with paragraph (5)(B)(ii)(V) of such section as in effect on the day before the date of enactment of this Act; and

(2) for discharges occurring on or after April 1, 2001, and before October 1, 2001, as if “c” in such paragraph equalled 1.66.

(c) CONFORMING AMENDMENT RELATING TO DE-TERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking “1997” and inserting “1997,”; and

(2) by inserting “, or any additional payments under such paragraph resulting from the application of section 302 of the Medicare, Medicaid, and

1 SCHIP Balanced Budget Refinement Act of 2000”  
 2 after “Balanced Budget Refinement Act of 1999”.

3 (d) CLERICAL AMENDMENTS.—Section  
 4 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended  
 5 by subsection (a), is amended by moving the indentation  
 6 of each of the following 2 ems to the left:

7 (1) Clauses (ii), (v), and (vi).

8 (2) Subclauses (I) through (VI) of clause (ii).

9 (3) Subclauses (I) and (II) of clause (vi) and  
 10 the flush sentence at the end of such clause.

11 **SEC. 303. DECREASE IN REDUCTIONS FOR DISPROPOR-**  
 12 **TIONATE SHARE HOSPITAL PAYMENTS.**

13 (a) IN GENERAL.—Section 1886(d)(5)(F)(ix) (42  
 14 U.S.C. 1395ww(d)(5)(F)(ix)) is amended—

15 (1) in subclause (III), by striking “each of fis-  
 16 cal years 2000 and 2001” and inserting “fiscal year  
 17 2000”;

18 (2) by redesignating subclauses (IV) and (V) as  
 19 subclauses (V) and (IV), respectively;

20 (3) in subclause (V), as redesignated, by strik-  
 21 ing “4 percent” and inserting “3 percent”; and

22 (4) by inserting after subclause (III) the fol-  
 23 lowing new subclause:

24 “(IV) during fiscal year 2001, such additional  
 25 payment amount shall be reduced by 2 percent;”.

1 (b) SPECIAL RULE FOR DSH PAYMENT.—Notwith-  
 2 standing the amendments made by subsection (a), for pur-  
 3 poses of making disproportionate share payments for sub-  
 4 section (d) hospitals (as defined in section 1886(d)(1)(B)  
 5 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))  
 6 for fiscal year 2001, the additional payment amount other-  
 7 wise determined under clause (ii) of section 1886(d)(5)(F)  
 8 of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F))—

9 (1) for discharges occurring on or after October  
 10 1, 2000, and before April 1, 2001, shall be adjusted  
 11 as provided by clause (ix)(III) of such section as in  
 12 effect on the day before the date of enactment of  
 13 this Act; and

14 (2) for discharges occurring on or after April 1,  
 15 2001, and before October 1, 2001, shall, instead of  
 16 being adjusted as provided by clause (ix)(IV) of such  
 17 section as in effect after the date of enactment of  
 18 this Act, shall be decreased by 1 percent.

19 (c) CONFORMING AMENDMENTS RELATING TO DE-  
 20 TERMINATION OF STANDARDIZED AMOUNT.—Section  
 21 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), is  
 22 amended—

23 (1) by striking “1989 or” and inserting  
 24 “1989,”; and



1           (2) by inserting “, or the enactment of section  
 2           303 of the Medicare, Medicaid, and SCHIP Bal-  
 3           anced Budget Further Refinement Act of 2000”  
 4           after “Omnibus Budget Reconciliation Act of 1990”.

5 **SEC. 304. MODIFICATION OF PAYMENT RATE FOR PUERTO**  
 6 **RICO HOSPITALS.**

7           (a) MODIFICATION OF PAYMENT RATE.—Section  
 8 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is  
 9 amended—

10           (1) in clause (i), by striking “October 1, 1997,  
 11           50 percent (” and inserting “October 1, 2000, 25  
 12           percent (for discharges between October 1, 1997,  
 13           and September 30, 2000, 50 percent,”; and

14           (2) in clause (ii), in the matter preceding sub-  
 15           clause (I), by striking “after October 1, 1997, 50  
 16           percent (” and inserting “after October 1, 2000, 75  
 17           percent (for discharges between October 1, 1997,  
 18           and September 30, 2000, 50 percent,”.

19           (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 20 2001.—

21           (1) IN GENERAL.—Notwithstanding the amend-  
 22           ment made by subsection (a), for purposes of mak-  
 23           ing payments for the operating costs of inpatient  
 24           hospital services of a section 1886(d) Puerto Rico  
 25           hospital for fiscal year 2001, the amount referred to

1 in the matter preceding clause (i) of section  
 2 1886(d)(9)(A) of the Social Security Act (42 U.S.C.  
 3 1395ww(d)(9)(A))—

4 (A) for discharges occurring on or after  
 5 October 1, 2000, and before April 1, 2001,  
 6 shall be determined in accordance with such  
 7 section as in effect on the day before the date  
 8 of enactment of this Act; and

9 (B) for discharges occurring on or after  
 10 April 1, 2001, and before October 1, 2001,  
 11 shall be determined—

12 (i) using 0 percent of the Puerto Rico  
 13 adjusted DRG prospective payment rate  
 14 referred to in clause (i) of such section;  
 15 and

16 (ii) using 100 percent of the dis-  
 17 charge-weighted average referred to in  
 18 clause (ii) of such section.

19 (2) SECTION 1886(d) PUERTO RICO HOSPITAL.—  
 20 For purposes of this subsection, the term “section  
 21 1886(d) Puerto Rico hospital” has the meaning  
 22 given the term “subsection (d) Puerto Rico hospital”  
 23 in the last sentence of section 1886(d)(9)(A) of the  
 24 Social Security Act (42 U.S.C. 1395ww(d)(9)(A)).

1 **SEC. 305. MEDPAC STUDY AND REPORT ON HOSPITAL AREA**  
2 **WAGE INDEXES.**

3 (a) STUDY.—

4 (1) IN GENERAL.—The Medicare Payment Ad-  
5 visory Commission established under section 1805 of  
6 the Social Security Act (42 U.S.C. 1395b–6) (in this  
7 section referred to as “MedPAC”) shall conduct a  
8 study on the hospital area wage indexes used in  
9 making payments to hospitals under section 1886(d)  
10 of the Social Security Act (42 U.S.C. 1395ww(d)),  
11 including an assessment of the accuracy of those in-  
12 dexes in reflecting geographic differences in wage  
13 and wage-related costs of hospitals.

14 (2) CONSIDERATIONS.—In conducting the study  
15 under paragraph (1), MedPAC shall consider—

16 (A) the appropriate method for deter-  
17 mining hospital area wage indexes;

18 (B) the appropriate portion of hospital  
19 payments that should be adjusted by the appli-  
20 cable area wage index;

21 (C) the appropriate method for adjusting  
22 the wage index by occupational mix; and

23 (D) the feasibility and impact of making  
24 changes (as determined appropriate by  
25 MedPAC) to the methods used to determine

1           such indexes, including the need for a data sys-  
2           tem required to implement such changes.

3           (b) REPORT.—Not later than 18 months after the  
4   date of enactment of this Act, MedPAC shall submit a  
5   report to the Secretary of Health and Human Services and  
6   Congress on the study conducted under subsection (a) to-  
7   gether with such recommendations for legislation and ad-  
8   ministrative action as MedPAC determines appropriate.

9   **SEC. 306. MEDPAC STUDY AND REPORT REGARDING CER-**  
10                   **TAIN HOSPITAL COSTS.**

11           (a) STUDY.—

12                   (1) IN GENERAL.—The Medicare Payment Ad-  
13   visory Commission established under section 1805 of  
14   the Social Security Act (42 U.S.C. 1395b–6) (in this  
15   section referred to as “MedPAC”) shall conduct a  
16   study on—

17                           (A) any increased costs incurred by sub-  
18   section (d) hospitals (as defined in paragraph  
19   (1)(B) of section 1886(d) of the Social Security  
20   Act (42 U.S.C. 1395ww(d))) in providing inpa-  
21   tient hospital services to medicare beneficiaries  
22   under title XVIII of such Act during the period  
23   beginning on October 1, 1983, and ending on  
24   September 30, 1999, that were attributable  
25   to—

1 (i) complying with new blood safety  
2 measure requirements; and

3 (ii) providing such services using new  
4 technologies;

5 (B) the extent to which the prospective  
6 payment system for such services under such  
7 section provides adequate and timely recogni-  
8 tion of such increased costs;

9 (C) the prospects for (and to the extent  
10 practicable, the magnitude of) cost increases  
11 that hospitals will incur in providing such serv-  
12 ices that are attributable to complying with new  
13 blood safety measure requirements and pro-  
14 viding such services using new technologies dur-  
15 ing the 10 years after the date of enactment of  
16 this Act; and

17 (D) the feasibility and advisability of es-  
18 tablishing mechanisms under such payment sys-  
19 tem to provide for more timely and accurate  
20 recognition of such cost increases in the future.

21 (2) CONSULTATION.—In conducting the study  
22 under this section, MedPAC shall consult with rep-  
23 resentatives of the blood community, including

24 (A) hospitals;

1 (B) organizations involved in the collection,  
 2 processing, and delivery of blood; and

3 (C) organizations involved in the develop-  
 4 ment of new blood safety technologies.

5 (b) REPORT.—Not later than 1 year after the date  
 6 of enactment of this Act, MedPAC shall submit a report  
 7 to the Secretary of Health and Human Services and Con-  
 8 gress on the study conducted under subsection (a) to-  
 9 gether with such recommendations for legislation and ad-  
 10 ministrative action as MedPAC determines appropriate.

## 11 **Subtitle B—PPS Exempt Hospitals**

### 12 **SEC. 311. PERMANENT GUARANTEE OF PRE-BBA PAYMENT** 13 **LEVELS FOR OUTPATIENT SERVICES FUR-** 14 **NISHED BY CHILDREN'S HOSPITALS.**

15 (a) IN GENERAL.—Section 1833(t) (42 U.S.C.  
 16 1395l(t)) is amended—

17 (1) in the heading of paragraph (7)(D)(ii), by  
 18 inserting “AND CHILDREN’S HOSPITALS” after “CAN-  
 19 CER HOSPITALS”; and

20 (2) in paragraphs (7)(D)(ii) and (11), by strik-  
 21 ing “section 1886(d)(1)(B)(v)” and inserting  
 22 “clause (iii) or (v) of section 1886(d)(1)(B)”.

23 (b) EFFECTIVE DATE.—The amendments made by  
 24 subsection (a) apply as if included in the enactment of  
 25 section 202 of BBRA.

1 **SEC. 312. PAYMENT FOR INPATIENT SERVICES OF REHA-**  
 2 **BILITATION HOSPITALS.**

3 (a) ASSISTANCE WITH ADMINISTRATIVE COSTS AS-  
 4 SOCIATED WITH COMPLETION OF PATIENT ASSESS-  
 5 MENT.—Section 1886(j)(3)(B) (42 U.S.C.  
 6 1395ww(j)(3)(B)) is amended by striking “98 percent”  
 7 and inserting “100 percent for fiscal year 2001 and 98  
 8 percent for fiscal year 2002”.

9 (b) ELECTION TO APPLY FULL PROSPECTIVE PAY-  
 10 MENT RATE WITHOUT PHASE-IN.—

11 (1) IN GENERAL.—Paragraph (1) of section  
 12 1886(j) (42 U.S.C. 1395ww(j)) is amended—

13 (A) in subparagraph (A), by inserting  
 14 “other than a facility making an election under  
 15 subparagraph (F)” before “, in a cost reporting  
 16 period”;

17 (B) in subparagraph (B), by inserting “or,  
 18 in the case of a facility making an election  
 19 under subparagraph (F), for any cost reporting  
 20 period described in such subparagraph,” after  
 21 “2002,”; and

22 (C) by adding at the end the following new  
 23 subparagraph:

24 “(F) ELECTION TO APPLY FULL PROSPEC-  
 25 TIVE PAYMENT SYSTEM.—A rehabilitation facil-  
 26 ity may elect, at least 30 days before the first

1 date on which the payment methodology under  
 2 this subsection applies, to have payment made  
 3 to the facility under this subsection under the  
 4 provisions of subparagraph (B) (rather than  
 5 subparagraph (A)) for each cost reporting pe-  
 6 riod to which such payment methodology ap-  
 7 plies.”.

8 (2) CLARIFICATION.—Paragraph (3)(B) of such  
 9 section is amended by inserting “but not taking into  
 10 account any payment adjustment resulting from an  
 11 election permitted under paragraph (1)(F)” after  
 12 “paragraphs (4) and (6)”.

13 (c) EFFECTIVE DATE.—The amendments made by  
 14 this section take effect as if included in the enactment of  
 15 BBA.

16 **SEC. 313. IMPLEMENTATION OF PROSPECTIVE PAYMENT**  
 17 **SYSTEM FOR LONG-TERM CARE HOSPITALS.**

18 (a) MODIFICATION OF REQUIREMENT.—In devel-  
 19 oping the prospective payment system required under sec-  
 20 tion 123 of BBRA (113 Stat. 1501A–331), the Secretary  
 21 of Health and Human Services shall examine the feasi-  
 22 bility and the impact of basing payment under such sys-  
 23 tem on the use of existing (or refined) hospital diagnosis-  
 24 related groups (DRGs) and the use of the most recently  
 25 available hospital discharge data.



(b) DEFAULT IMPLEMENTATION OF SYSTEM BASED ON EXISTING DRG METHODOLOGY.—If the Secretary is unable to implement the prospective payment system described in subsection (a) by October 1, 2002, the Secretary shall implement a prospective payment system for long-term care hospitals that bases payment under such a system using existing hospital diagnosis-related groups (DRGs), consistent with subsection (a), for such services furnished on or after that date.

## **Subtitle C—Skilled Nursing Facilities**

### **SEC. 321. REVISION TO THE SKILLED NURSING FACILITY (SNF) MARKET BASKET UPDATE FOR FISCAL YEARS 2001 AND 2002.**

(a) REVISION.—Section 1888(e)(4)(E)(ii)(II) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)(II)) is amended by striking “minus 1 percentage point” and inserting “plus 1 percentage point”.

(b) SPECIAL RULE FOR PAYMENT FOR SKILLED NURSING FACILITY SERVICES FOR FISCAL YEAR 2001.—Notwithstanding the amendment made by subsection (a), for purposes of making payments for covered skilled nursing facility services under section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for fiscal year 2001,

1 the Federal per diem rate referred to in paragraph  
2 (4)(E)(ii) of such section—

3 (1) for the period beginning on October 1,  
4 2000, and ending on March 31, 2001, shall be the  
5 rate determined in accordance with subclause (II) of  
6 such paragraph as in effect on the day before the  
7 date of enactment of this Act; and

8 (2) for the period beginning on April 1, 2001,  
9 and ending on September 30, 2001, shall be the rate  
10 computed for fiscal year 2000 pursuant to subclause  
11 (I) of such paragraph increased by the skilled nurs-  
12 ing facility market basket percentage change for fis-  
13 cal year 2001 plus 3 percentage points.

14 **SEC. 322. APPLICATION OF SNF CONSOLIDATED BILLING**  
15 **REQUIREMENT LIMITED TO PART A COV-**  
16 **ERED STAYS.**

17 (a) IN GENERAL.—Section 1862(a)(18) (42 U.S.C.  
18 1395y(a)(18)) is amended by inserting after “(as deter-  
19 mined under regulations)” the following: “during a period  
20 in which the resident is provided covered post-hospital ex-  
21 tended care services”.

22 (b) CONFORMING AMENDMENTS.—(1) Section  
23 1842(b)(6)(E) (42 U.S.C. 1395u(b)(6)(E)) is amended by  
24 striking “in the case of an item or service (other than serv-  
25 ices described in section 1888(e)(2)(A)(ii))” and inserting

1 “in the case of services described in section  
2 1861(s)(2)(D)”.

3 (2) Section 1866(a)(1)(H)(ii)(I) (42 U.S.C.  
4 1395cc(a)(1)(H)(ii)(I)) is amended by inserting after  
5 “who is a resident of the skilled nursing facility” the fol-  
6 lowing: “during a period in which the resident is provided  
7 covered post-hospital extended care services (or, for serv-  
8 ices described in section 1861(s)(2)(D), that are furnished  
9 to such an individual without regard to such period)”.

10 (c) EFFECTIVE DATE.—The amendment made by  
11 subsection (a) applies to services furnished on or after  
12 January 1, 2001.

13 (d) OVERSIGHT.—The Secretary of Health and  
14 Human Services, through the Office of the Inspector Gen-  
15 eral in the Department of Health and Human Services  
16 or otherwise, shall monitor payments made under part B  
17 of the title XVIII of the Social Security Act for items and  
18 services furnished to residents of skilled nursing facilities  
19 during a time in which the residents are not being pro-  
20 vided medicare covered post-hospital extended care serv-  
21 ices to ensure that there is not duplicate billing for serv-  
22 ices or excessive services provided.

1 **SEC. 323. REEXAMINATION OF, AND AUTHORITY TO REVISE,**  
2 **THE SKILLED NURSING FACILITY MARKET**  
3 **BASKET PERCENTAGE INCREASE.**

4 (a) REEXAMINATION.—

5 (1) IN GENERAL.—The Secretary of Health and  
6 Human Services shall reexamine the skilled nursing  
7 facility market basket percentage (as defined in  
8 paragraph (5)(B) of section 1888(e) of the Social  
9 Security Act (42 U.S.C. 1395yy(e)) that was used in  
10 making the update to the first fiscal year under  
11 paragraph (4)(B) of such section under the prospec-  
12 tive payment system for skilled nursing facility serv-  
13 ices.

14 (2) SPECIFIC ELEMENTS.—In conducting the  
15 reexamination under paragraph (1), the Secretary of  
16 Health and Human Services shall account for costs  
17 based on actual data and actual medicare skilled  
18 nursing facility cost increases.

19 (b) AUTHORITY.—Notwithstanding any other provi-  
20 sion of law, the Secretary of Health and Human Services  
21 shall make adjustments to payments under the prospective  
22 payment system under section 1888(e) of the Social Secu-  
23 rity Act (42 U.S.C. 1395yy(e)) for covered skilled nursing  
24 facility services furnished in fiscal year 2002 to reflect any  
25 necessary adjustments to such payments as is appropriate

1 as a result of the reexamination conducted under sub-  
 2 section (a).

3 (c) PUBLICATION.—

4 (1) IN GENERAL.—Not later than April 1,  
 5 2001, the Secretary of Health and Human Services  
 6 shall publish for public comment a description of—

7 (A) whether the Secretary will make any  
 8 adjustments pursuant to this section; and

9 (B) if so, the form of such adjustments.

10 (2) FINAL FORM.—Not later than August 1,  
 11 2001, the Secretary of Health and Human Services  
 12 shall publish the description described in paragraph  
 13 (1) in final form.

## 14 **Subtitle D—Hospice Care**

### 15 **SEC. 331. REVISION OF MARKET BASKET INCREASE FOR** 16 **2001 AND 2002.**

17 (a) IN GENERAL.—Section 1814(i)(1)(C)(ii) (42  
 18 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

19 (1) by redesignating subclause (VII) as sub-  
 20 clause (VIII);

21 (2) in subclause (VI)—

22 (A) by striking “through 2002” and insert-  
 23 ing “through 2000”; and

24 (B) by striking “and” at the end; and

1           (3) by inserting after subclause (VI) the fol-  
2       lowing new subclause:

3           “(VII) for each of fiscal years 2001 and 2002,  
4       the market basket percentage increase for the fiscal  
5       year plus 1.0 percentage point; and”.

6       (b) REPEAL OF BBRA TEMPORARY INCREASE.—

7           (1) IN GENERAL.—Section 131 of BBRA (113  
8       Stat. 1501A–333) is repealed.

9           (2) EFFECTIVE DATE.—The amendments made  
10      by paragraph (1) shall take effect as if included in  
11      the enactment of BBRA.

12      (c) TRANSITION DURING FISCAL YEAR 2001.—Not-  
13      withstanding the amendments made by subsection (a), for  
14      purposes of making payments for hospice care under sec-  
15      tion 1814(i) of the Social Security Act (42 U.S.C.  
16      1395f(i)) for fiscal year 2001, the payment rates referred  
17      to in paragraph (1)(C) of such section—

18           (1) for the period beginning on October 1,  
19      2000, and ending on March 31, 2001, shall be the  
20      rate determined in accordance with the law as in ef-  
21      fect on the day before the date of enactment of this  
22      Act; and

23           (2) for the period beginning on April 1, 2001,  
24      and ending on September 30, 2001, shall be the rate  
25      that would have been determined under paragraph

1 (1) if “plus 3.0 percentage points” were substituted  
 2 for “minus 1.0 percentage points under paragraph  
 3 (1)(C)(ii)(VI) of such section for fiscal year 2001.

4 (d) TECHNICAL AMENDMENT.—Section  
 5 1814(a)(7)(A)(ii) (42 U.S.C. 1395f(a)(7)(A)(ii)) is  
 6 amended by striking the period at the end and inserting  
 7 a semicolon.

8 **SEC. 332. STUDY AND REPORT ON PHYSICIAN CERTIFI-**  
 9 **CATION REQUIREMENT FOR HOSPICE BENE-**  
 10 **FITS.**

11 (a) IN GENERAL.—The Secretary of Health and  
 12 Human Services shall conduct a study to examine the ap-  
 13 propriateness of the certification regarding terminal ill-  
 14 ness of an individual under section 1814(a)(7) of the So-  
 15 cial Security Act (42 U.S.C. 1395f(a)(7)) that is required  
 16 in order for such individual to receive hospice benefits  
 17 under the medicare program under title XVIII of such Act  
 18 (42 U.S.C. 1395 et seq.).

19 (b) REPORT.—Not later than 1 year after the date  
 20 of enactment of this Act, the Secretary of Health and  
 21 Human Services shall submit a report to Congress on the  
 22 study conducted under subsection (a), together with any  
 23 recommendations for legislation that the Secretary deems  
 24 appropriate.

1 **SEC. 333. HOSPICE DEMONSTRATION PROGRAM AND HOS-**  
2 **PICE EDUCATION GRANTS.**

3 (a) DEFINITIONS.—In this section:

4 (1) DEMONSTRATION PROGRAM.—The term  
5 “demonstration program” means the Hospice Dem-  
6 onstration Program established by the Secretary  
7 under subsection (b)(1).

8 (2) HOSPICE CARE; HOSPICE PROGRAM.—Ex-  
9 cept as otherwise provided, the terms “hospice care”  
10 and “hospice program” have the meanings given  
11 such terms in paragraphs (1) and (2) of section  
12 1861(dd) of the Social Security Act (42 U.S.C.  
13 1395x(dd)).

14 (3) MEDICARE BENEFICIARY.—The term  
15 “medicare beneficiary” means any individual who is  
16 entitled to benefits under part A or enrolled under  
17 part B of the medicare program, including any indi-  
18 vidual enrolled in a Medicare+Choice plan offered  
19 by a Medicare+Choice organization under part C of  
20 such program.

21 (4) MEDICARE PROGRAM.—The term “medicare  
22 program” means the health benefits program under  
23 title XVIII of the Social Security Act (42 U.S.C.  
24 1395 et seq.).

25 (5) SECRETARY.—The term “Secretary” means  
26 the Secretary of Health and Human Services, acting



1 through the Administrator of the Health Care Fi-  
2 nancing Administration.

3 (6) SERIOUSLY ILL.—The term “seriously ill”  
4 has the meaning given such term by the Secretary  
5 (in consultation with hospice programs and academic  
6 experts in end-of-life care), except that the Secretary  
7 may not limit such term to individuals that are ter-  
8 minally ill (as defined in section 1861(dd)(3) of the  
9 Social Security Act (42 U.S.C. 1395x(dd)(3))).

10 (b) HOSPICE DEMONSTRATION PROGRAM.—

11 (1) ESTABLISHMENT.—Not later than 2 years  
12 after the date of enactment of this Act, the Sec-  
13 retary shall establish a Hospice Demonstration Pro-  
14 gram in accordance with the provisions of this sub-  
15 section to increase the utility of hospice care for se-  
16 riously ill medicare beneficiaries.

17 (2) PARTICIPATION.—

18 (A) HOSPICE PROGRAMS.—Except as pro-  
19 vided in paragraph (4)(A), only a hospice pro-  
20 gram with an agreement under section 1866 of  
21 the Social Security Act (42 U.S.C. 1395cc), a  
22 consortium of such hospice programs, or a  
23 State hospice association may participate in the  
24 demonstration program.

1 (B) MEDICARE BENEFICIARIES.—The Sec-  
2 retary shall permit any seriously ill medicare  
3 beneficiary residing in the service area of a hos-  
4 pice program participating in the demonstration  
5 program to participate in the demonstration  
6 program on a voluntary basis.

7 (3) HOSPICE CARE UNDER DEMONSTRATION  
8 PROGRAM.—The provisions of section 1814(i) of the  
9 Social Security Act (42 U.S.C. 1395f(i)) shall apply  
10 to the payment for hospice care provided under the  
11 demonstration program, except that—

12 (A) notwithstanding section 1862(a)(1)(C)  
13 of such Act (42 U.S.C. 1395y(a)(1)(C)), the  
14 Secretary shall provide for reimbursement for  
15 hospice care provided under the supportive and  
16 comfort care benefit established under para-  
17 graph (4);

18 (B) any licensed nurse practitioner or phy-  
19 sician assistant may admit a seriously ill medi-  
20 care beneficiary as the primary care provider  
21 when necessary and within the scope of practice  
22 of such practitioner or assistant under State  
23 law;

24 (C) if a community does not have a quali-  
25 fied social worker, any professional (other than

1 a social worker) who has the necessary knowl-  
2 edge, skills, and ability to provide medical social  
3 services may provide such services;

4 (D) the Secretary shall waive any require-  
5 ment that nursing facilities used for respite  
6 care have skilled nurses on the premises 24  
7 hours per day;

8 (E) the Secretary shall permit respite care  
9 to be provided to a seriously ill medicare bene-  
10 ficiary at home; and

11 (F) the Secretary shall waive reimburse-  
12 ment regulations to provide—

13 (i) reimbursement for consultations  
14 and preadmission informational visits, even  
15 if the seriously ill medicare beneficiary  
16 does not elect hospice care (including the  
17 supportive and comfort care benefit under  
18 paragraph (4)) at that time;

19 (ii) except with respect to the sup-  
20 portive and comfort care benefit under  
21 paragraph (4), a minimum payment for  
22 hospice care provided under the dem-  
23 onstration program based on the provision  
24 of hospice care to a seriously ill medicare  
25 beneficiary for a period of 14 days that—

1 (I) the Secretary shall pay to any  
2 hospice program participating in the  
3 demonstration program and providing  
4 hospice care (regardless of the length  
5 of stay of the seriously ill medicare  
6 beneficiary); and

7 (II) may not be less than the  
8 amount of payment that would have  
9 been made for hospice care if payment  
10 had been made at the daily rate of  
11 payment for such care under section  
12 1814(i) of the Social Security Act (42  
13 U.S.C. 1395f(i));

14 (iii) an increase in the reimbursement  
15 rates for hospice care to offset—

16 (I) changes in hospice care and  
17 oversight under the demonstration  
18 program; and

19 (II) the higher costs of providing  
20 hospice care in rural areas due to lack  
21 of economies of scale or large geo-  
22 graphic areas;

23 (iv) direct payment of any nurse prac-  
24 titioner or physician assistant practicing  
25 within the scope of State law in relation to

hospice care provided by such practitioner  
or assistant; and

(v) a per diem rate of payment for in-  
home care under subparagraph (E) that  
reflects the range of care needs of the seri-  
ously ill medicare beneficiary and that—

(I) in the case of a seriously ill  
medicare beneficiary that needs rou-  
tine care, is not less than 150 percent,  
and not more than 200 percent, of the  
routine home care rate for hospice  
care; and

(II) in the case of a seriously ill  
medicare beneficiary that needs acute  
care, is equal to the continuous home  
care day rate for hospice care.

(4) SUPPORTIVE AND COMFORT CARE BEN-  
EFIT.—

(A) IN GENERAL.—For purposes of the  
demonstration program, the Secretary shall es-  
tablish a supportive and comfort care benefit  
for any seriously ill medicare beneficiary elect-  
ing hospice care.

(B) PARTICIPATION.—Any individual or  
entity with an agreement under section 1866 of

1 the Social Security Act (42 U.S.C. 1395cc) may  
 2 furnish items or services covered under the sup-  
 3 portive and comfort care benefit.

4 (C) BENEFIT.—Under the supportive and  
 5 comfort care benefit, any seriously ill medicare  
 6 beneficiary may—

7 (i) continue to receive benefits for dis-  
 8 ease and symptom modifying treatment  
 9 under the medicare program (and the Sec-  
 10 retary may not require or prohibit any spe-  
 11 cific treatment or decision);

12 (ii) receive case management and hos-  
 13 pice care through a hospice program par-  
 14 ticipating in the demonstration program  
 15 (for which payment shall be made under  
 16 paragraph (3)(F)(ii)); and

17 (iii) receive information and experi-  
 18 ence in order to better understand the util-  
 19 ity of hospice care.

20 (D) PAYMENT.—The Secretary shall estab-  
 21 lish procedures under which the Secretary pays  
 22 for items and services furnished to seriously ill  
 23 medicare beneficiaries under the supportive and  
 24 comfort care benefit on a fee-for-service basis.

25 (5) CONDUCT OF DEMONSTRATION PROGRAM.—

1 (A) SITES.—The demonstration program  
2 shall be conducted in 3 sites, only 1 of which  
3 may be multistate.

4 (B) SELECTION OF SITES.—

5 (i) IN GENERAL.—Except as provided  
6 in clause (ii), the Secretary shall select  
7 demonstration sites, on the basis of pro-  
8 posals submitted under subparagraph (C),  
9 that are located in geographic areas that—

10 (I) include both urban and rural  
11 hospice programs; and

12 (II) are geographically diverse  
13 and readily accessible to a significant  
14 number of medicare beneficiaries.

15 (ii) EXCEPTIONS.—

16 (I) UNDERSERVED URBAN  
17 AREAS.—If a geographic area does  
18 not have any rural hospice program  
19 available to participate in the dem-  
20 onstration program, such area may  
21 substitute an underserved urban area,  
22 but the Secretary shall give priority to  
23 those proposals that include a rural  
24 hospice program.

1 (II) SPECIFIC SITE.—The Sec-  
2 retary shall select 1 demonstration  
3 site in the State in which, according  
4 to the Hospital Referral Region of  
5 Residence, 1994–1995, as listed in the  
6 Dartmouth Atlas of Health Care  
7 1998, the largest metropolitan area of  
8 such State had the lowest percentage  
9 of medicare beneficiary deaths in a  
10 hospital compared to the largest met-  
11 ropolitan area of each other State and  
12 the percentage of enrollees who expe-  
13 rienced intensive care during the last  
14 6 months of life was 21.5 percent.

15 (C) PROPOSALS.—

16 (i) IN GENERAL.—Under the dem-  
17 onstration program, the Secretary shall ac-  
18 cept proposals by any State hospice asso-  
19 ciation, hospice program, or consortium of  
20 hospice programs at such time, in such  
21 manner, and in such form as the Secretary  
22 may reasonably require.

23 (ii) RESEARCH DESIGNS.—The Sec-  
24 retary shall permit research designs that  
25 use time series, sequential implementation



1 of the intervention, randomization by wait  
2 list, or any other design that allows the  
3 strongest possible implementation of the  
4 demonstration program.

5 (D) FACILITATION OF EVALUATION.—The  
6 Secretary shall design the demonstration pro-  
7 gram to facilitate the evaluation conducted  
8 under paragraph (7).

9 (6) DURATION.—The Secretary shall conduct  
10 the demonstration program for a period of 3 years.

11 (7) EVALUATION.—During the 18-month period  
12 following the completion of the demonstration pro-  
13 gram, the Secretary shall conduct an evaluation of  
14 the demonstration program in order to determine—

15 (A) the short-term and long-term costs and  
16 benefits of changing hospice care provided  
17 under the medicare program to include the  
18 items, services, and reimbursement options pro-  
19 vided under the demonstration program;

20 (B) whether any increase in payments for  
21 hospice care provided under the medicare pro-  
22 gram is offset by savings in other parts of the  
23 medicare program;

24 (C) the projected cost of implementing the  
25 demonstration program on a national basis; and

1 (D) in consultation with hospice organiza-  
2 tions and hospice programs (including organiza-  
3 tions and programs that represent rural areas),  
4 whether a payment system based on diagnosis-  
5 related groups is useful for administering the  
6 hospice care provided under the medicare pro-  
7 gram.

8 (8) REPORTS TO CONGRESS.—

9 (A) INTERIM REPORT.—Not later than 2  
10 years after the implementation of the dem-  
11 onstration program, the Secretary, in consulta-  
12 tion with participants in the program, shall sub-  
13 mit to the to the Committee on Ways and  
14 Means of the House of Representatives and to  
15 the Committee on Finance of the Senate an in-  
16 terim report on the demonstration program.

17 (B) FINAL REPORT.—Not later than 2  
18 years after the date on which the demonstration  
19 program ends, the Secretary shall submit to the  
20 committees described in subparagraph (A) a  
21 final report on the demonstration program that  
22 includes the results of the evaluation conducted  
23 under paragraph (7) and recommendations for  
24 appropriate legislative changes.

1           (9) WAIVER OF MEDICARE REQUIREMENTS.—

2           The Secretary shall waive compliance with such re-  
3           quirements of the medicare program to the extent  
4           and for the period the Secretary finds necessary for  
5           the conduct of the demonstration program.

6           (10) SPECIAL RULES FOR PAYMENT OF

7           MEDICARE+CHOICE ORGANIZATIONS.—The Sec-  
8           retary shall establish procedures under which the  
9           Secretary provides for an appropriate adjustment in  
10          the monthly payments made under section 1853 of  
11          the Social Security Act (42 U.S.C. 1395w-23) to  
12          any Medicare+Choice organization offering a  
13          Medicare+Choice plan to reflect the participation of  
14          each medicare beneficiary enrolled in such plan in  
15          the demonstration program.

16          (c) HOSPICE EDUCATION GRANT PROGRAM.—

17                 (1) ESTABLISHMENT.—The Secretary shall es-  
18                 tablish a Hospice Education Grant Program under  
19                 which the Secretary awards education grants to hos-  
20                 pice programs participating in the demonstration  
21                 program for the purpose of providing information  
22                 about—

23                         (A) hospice care under the medicare pro-  
24                         gram; and

1 (B) the benefits available to medicare  
2 beneficiaries under the demonstration program.

3 (2) USE OF FUNDS.—Grants awarded under  
4 paragraph (1) shall be used—

5 (A) to provide—

6 (i) individual or group education to  
7 medicare beneficiaries and the families of  
8 such beneficiaries; and

9 (ii) individual or group education of  
10 the medical and mental health community  
11 caring for medicare beneficiaries; and

12 (B) to test strategies to improve the gen-  
13 eral public knowledge about hospice care under  
14 the medicare program and the benefits available  
15 to seriously ill medicare beneficiaries under the  
16 demonstration program.

17 (d) FUNDING.—

18 (1) HOSPICE DEMONSTRATION PROGRAM.—

19 (A) IN GENERAL.—Except as provided in  
20 subparagraph (B), expenditures made for the  
21 demonstration program shall be in lieu of the  
22 funds that would have been provided to partici-  
23 pating hospices under section 1814(i) of the So-  
24 cial Security Act (42 U.S.C. 1395f(i)).

1 (B) SUPPORTIVE AND COMFORT CARE  
 2 BENEFIT.—The Secretary shall pay any ex-  
 3 penses for the supportive and comfort care ben-  
 4 efit established under subsection (a)(4) from  
 5 the Federal Hospital Insurance Trust Fund es-  
 6 tablished under section 1817 of the Social Secu-  
 7 rity Act (42 U.S.C. 1395i) and the Federal  
 8 Supplementary Medical Insurance Trust Fund  
 9 established under section 1841 of such Act (42  
 10 U.S.C. 1395t), in such proportion as the Sec-  
 11 retary determines is appropriate.

12 (2) HOSPICE EDUCATION GRANTS.—The Sec-  
 13 retary is authorized to expend such sums as may be  
 14 necessary for the purposes of carrying out the Hos-  
 15 pice Education Grant program established under  
 16 subsection (c)(1) from the Research and Demonstra-  
 17 tion Budget of the Health Care Financing Adminis-  
 18 tration.

## 19 **Subtitle E—Other Provisions**

### 20 **SEC. 341. SIX-MONTH DELAY IN IMPLEMENTATION OF RULE** 21 **REGARDING PROVIDER-BASED CRITERIA.**

22 The Secretary of Health and Human Services may  
 23 not implement the provider-based criteria contained in the  
 24 final rule that was published in the Federal Register by

1 the Health Care Financing Administration on April 7,  
 2 2000 (65 Fed. Reg. 18434) until after July 9, 2001.

3 **TITLE IV—PROVISIONS**  
 4 **RELATING TO PART B**  
 5 **Subtitle A—Hospital Outpatient**  
 6 **Services**

7 **SEC. 401. APPLICATION OF TRANSITIONAL CORRIDOR TO**  
 8 **CERTAIN HOSPITALS THAT DID NOT SUBMIT**  
 9 **A 1996 COST REPORT.**

10 (a) IN GENERAL.—Section 1833(t)(7)(F)(ii)(I) (42  
 11 U.S.C. 1395l(t)(7)(F)(ii)(I)) is amended by inserting “(or,  
 12 in the case of a hospital that did not submit a cost report  
 13 for such period, during the first cost reporting period end-  
 14 ing in a year after 1996 and before 2001 for which the  
 15 hospital submitted a cost report)” after “1996”.

16 (b) EFFECTIVE DATE.—The amendment made by  
 17 subsection (a) shall take effect as if included in the enact-  
 18 ment of section 202 of BBRA.

19 **SEC. 402. CLARIFYING PROCESS AND STANDARDS FOR DE-**  
 20 **TERMINING ELIGIBILITY OF DEVICES FOR**  
 21 **PASS-THROUGH PAYMENTS UNDER HOSPITAL**  
 22 **OUTPATIENT PPS.**

23 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.  
 24 1395l(t)(6)) is amended—

1           (1) by redesignating subparagraphs (C) and  
2           (D) as subparagraphs (D) and (E), respectively; and  
3           (2) by striking subparagraph (B) and inserting  
4           the following new subparagraphs:

5                   “(B) USE OF CATEGORIES IN DETER-  
6           MINING ELIGIBILITY OF A DEVICE FOR PASS-  
7           THROUGH PAYMENTS.—The following provi-  
8           sions apply for purposes of determining whether  
9           a medical device qualifies for additional pay-  
10          ments under clause (ii) or (iv) of subparagraph  
11          (A):

12                   “(i) ESTABLISHMENT OF INITIAL CAT-  
13          EGORIES.—The Secretary shall initially es-  
14          tablish under this clause categories of med-  
15          ical devices based on type of device by  
16          April 1, 2001. Such categories shall be es-  
17          tablished in a manner such that each med-  
18          ical device that meets the requirements of  
19          clause (ii) or (iv) of subparagraph (A) as  
20          of such date is included in such a category  
21          and no such device is included in more  
22          than one category. For purposes of the  
23          preceding sentence, whether a medical de-  
24          vice meets such requirements as of such  
25          date shall be determined on the basis of

the program memoranda issued before such date or if the Secretary determines the medical device would have been included in the program memoranda but for the requirement of subparagraph (A)(iv)(I). The categories may be established under this clause by program memorandum or otherwise, after consultation with groups representing hospitals, manufacturers of medical devices, and other affected parties.

“(ii) ESTABLISHING CRITERIA FOR ADDITIONAL CATEGORIES.—

“(I) IN GENERAL.—The Secretary shall establish criteria that will be used for creation of additional categories (other than those established under clause (i)) through rulemaking (which may include use of an interim final rule with comment period).

“(II) STANDARD.—Such categories shall be established under this clause in a manner such that no medical device is described by more than one category. Such criteria shall in-



1           clude a test of whether the average  
2           cost of devices that would be included  
3           in a category and are in use at the  
4           time the category is established is not  
5           insignificant, as described in subpara-  
6           graph (A)(iv)(II).

7                   “(III) DEADLINE.—Criteria shall  
8           first be established under this clause  
9           by July 1, 2001. The Secretary may  
10          establish in compelling circumstances  
11          categories under this clause before the  
12          date such criteria are established.

13                   “(IV) ADDING CATEGORIES.—  
14          The Secretary shall promptly establish  
15          a new category of medical device  
16          under this clause for any medical de-  
17          vice that meets the requirements of  
18          subparagraph (A)(iv) and for which  
19          none of the categories in effect (or  
20          that were previously in effect) is ap-  
21          propriate.

22                   “(iii) PERIOD FOR WHICH CATEGORY  
23          IS IN EFFECT.—A category of medical de-  
24          vices established under clause (i) or clause  
25          (ii) shall be in effect for a period of at

1 least 2 years, but not more than 3 years,  
2 that begins—

3 “(I) in the case of a category es-  
4 tablished under clause (i), on the first  
5 date on which payment was made  
6 under this paragraph for any device  
7 described by such category (including  
8 payments made during the period be-  
9 fore April 1, 2001); and

10 “(II) in the case of any other  
11 category, on the first date on which  
12 payment is made under this para-  
13 graph for any medical device that is  
14 described by such category.

15 “(iv) REQUIREMENTS TREATED AS  
16 MET.—A medical device shall be treated as  
17 meeting the requirements of subparagraph  
18 (A)(iv) if—

19 “(I) the device is described by a  
20 category established and in effect  
21 under clause (i); or

22 “(II) the device is described by a  
23 category established and in effect  
24 under clause (ii) and an application  
25 under section 515 of the Federal

1 Food, Drug, and Cosmetic Act has  
2 been approved with respect to the de-  
3 vice, or the device has been cleared for  
4 market under section 510(k) of such  
5 Act, or the device is exempt from the  
6 requirements of section 510(k) of  
7 such Act pursuant to subsection (l) or  
8 (m) of section 510 of such Act or sec-  
9 tion 520(g) of such Act.

10 Nothing in this clause shall be construed  
11 as requiring an application or prior ap-  
12 proval (other than that described in sub-  
13 clause (II)) in order for a device to qualify  
14 for payment under this paragraph.

15 “(C) LIMITED PERIOD OF PAYMENT.—

16 “(i) DRUGS AND BIOLOGICALS.—The  
17 payment under this paragraph with respect  
18 to a drug or biological shall only apply dur-  
19 ing a period of at least 2 years, but not  
20 more than 3 years, that begins—

21 “(I) on the first date this sub-  
22 section is implemented in the case of  
23 a drug or biological described in  
24 clause (i), (ii), or (iii) of subparagraph  
25 (A) and in the case of a drug or bio-

1           logical described in subparagraph  
 2           (A)(iv) and for which payment under  
 3           this part is made as an outpatient  
 4           hospital service before such first date;  
 5           or

6                       “(II) in the case of a drug or bio-  
 7           logical described in subparagraph  
 8           (A)(iv) not described in subclause (I),  
 9           on the first date on which payment is  
 10          made under this part for the drug or  
 11          biological as an outpatient hospital  
 12          service.

13                   “(ii) MEDICAL DEVICES.—Payment  
 14          shall be made under this paragraph with  
 15          respect to a medical device only if such  
 16          device—

17                       “(I) is described by a category of  
 18          medical devices established and in ef-  
 19          fect under subparagraph (B); and

20                       “(II) is provided as part of a  
 21          service (or group of services) paid for  
 22          under this subsection and provided  
 23          during the period for which such cat-  
 24          egory is in effect under such subpara-  
 25          graph.”.

1 (b) CONFORMING AMENDMENTS.—Section 1833(t)  
 2 (42 U.S.C. 1395l(t)) amended—

3 (1) in paragraph (6)(A)(iv)(II), by striking “the  
 4 cost of the device, drug, or biological” and inserting  
 5 “the cost of the drug or biological or the average  
 6 cost of the category of devices”;

7 (2) in paragraph (6)(D) (as redesignated by  
 8 subsection (a)(1)), by striking “subparagraph  
 9 (D)(iii)” in the matter preceding clause (i) and in-  
 10 serting “subparagraph (E)(iii)”; and

11 (3) in paragraph (12)(E), by striking “addi-  
 12 tional payments (consistent with paragraph (6)(B))”  
 13 and inserting “additional payments, the determina-  
 14 tion and deletion of initial and new categories (con-  
 15 sistent with subparagraphs (B) and (C) of para-  
 16 graph (6))”.

17 (c) EFFECTIVE DATE.—The amendments made by  
 18 this section take effect on the date of the enactment of  
 19 this Act.

20 (d) TRANSITION.—In the case of a medical device  
 21 provided as part of a service (or group of services) fur-  
 22 nished during the period beginning on the date that is 30  
 23 days after the date of the enactment of this Act and end-  
 24 ing on the day before the initial categories are imple-  
 25 mented under subparagraph (B)(i) of section 1833(t)(6)

1 of the Social Security Act (as amended by subsection (a)),  
 2 payment shall be made for such device under such section  
 3 in accordance with the provisions in effect before the date  
 4 of the enactment of this Act, except that (notwithstanding  
 5 subparagraph (C)(ii) of such section, as so amended) pay-  
 6 ment shall also be made for such a device that is not in-  
 7 cluded in a program memorandum described in such sub-  
 8 paragraph if the Secretary determines that the device is  
 9 likely to be described by such an initial category.

10 **SEC. 403. CONTRAST ENHANCED DIAGNOSTIC PROCE-**  
 11 **DURES UNDER HOSPITAL PROSPECTIVE PAY-**  
 12 **MENT SYSTEM.**

13 (a) SEPARATE CLASSIFICATION.—Section 1833(t)(2)  
 14 (42 U.S.C. 1395l(t)(2)) is amended—

15 (1) by striking “and” at the end of subpara-  
 16 graph (E);

17 (2) by striking the period at the end of sub-  
 18 paragraph (F) and inserting “; and”; and

19 (3) by inserting after subparagraph (F) the fol-  
 20 lowing new subparagraph:

21 “(G) the Secretary shall create additional  
 22 groups of covered OPD services that classify  
 23 separately those procedures that utilize contrast  
 24 media from those that do not.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 this section shall be effective as if included in the enact-  
 3 ment of BBA.

4 **SEC. 404. TRANSITIONAL PASS-THROUGH FOR CONTRAST**  
 5 **AGENTS.**

6 (a) IN GENERAL.—Section 1833(t)(6) (42 U.S.C.  
 7 1395l(t)(6)), as amended by section 402, is amended—

8 (1) in subparagraph (A)(iv)—

9 (A) in the heading, by striking “AND  
 10 BIOLOGICALS” and inserting “BIOLOGICALS,  
 11 AND CONTRAST AGENTS”;

12 (B) in the matter preceding subclause (I),  
 13 by striking “or biological” and inserting “bio-  
 14 logical, or contrast agent”;

15 (C) in subclause (I), by striking “or bio-  
 16 logical” and inserting “biological, or contrast  
 17 agent”; and

18 (D) in subclause (II), by striking “or bio-  
 19 logical” and inserting “, biological, or contrast  
 20 agent”;

21 (2) in subparagraph (C)—

22 (A) in the heading, by striking “AND  
 23 BIOLOGICALS” and inserting “BIOLOGICALS,  
 24 AND CONTRAST AGENTS”; and

1 (B) by striking “or biological” the first,  
 2 third, fourth, and fifth place it appears and in-  
 3 serting “, biological, or contrast agent”; and  
 4 (3) in subparagraph (D)—

5 (A) in the matter preceding clause (i), by  
 6 striking “or biological” and inserting “biologi-  
 7 cal, or contrast agent”; and

8 (B) in clause (i), by striking “or biologi-  
 9 cal” each place it appears and inserting “, bio-  
 10 logical, or contrast agent”.

11 (b) EFFECTIVE DATE.—The amendments made by  
 12 subsection (a) shall take effect on January 1, 2001.

## 13 **Subtitle B—Provisions Relating to** 14 **Physicians**

### 15 **SEC. 411. MEDPAC STUDY ON THE RESOURCE-BASED PRAC-** 16 **TICE EXPENSE SYSTEM.**

17 (a) STUDY.—The Medicare Payment Advisory Com-  
 18 mission established under section 1805 of the Social Secu-  
 19 rity Act (42 U.S.C. 1395b–6) (in this section referred to  
 20 as “MedPAC”) shall conduct a study on the refinements  
 21 to the practice expense relative value units during the  
 22 transition to a resource-based practice expense system for  
 23 physician payments under the medicare program under  
 24 title XVIII of the Social Security Act (42 U.S.C. 1395



1 et seq.) (in this section referred to as the “medicare pro-  
2 gram”).

3 (b) REPORT.—Not later than July 1, 2001, MedPAC  
4 shall submit a report to the Secretary of Health and  
5 Human Services and Congress on the study conducted  
6 under subsection (a) together with recommendations  
7 regarding—

8 (1) any change or adjustment that is appro-  
9 priate to ensure full access to a spectrum of care for  
10 beneficiaries under the medicare program; and

11 (2) the appropriateness of payments to physi-  
12 cians.

13 **SEC. 412. GAO STUDIES AND REPORTS ON MEDICARE PAY-**  
14 **MENTS.**

15 (a) GAO STUDY ON HCFA POST-PAYMENT AUDIT  
16 PROCESS.—

17 (1) STUDY.—The Comptroller General of the  
18 United States shall conduct a study on the post-pay-  
19 ment audit process under the medicare program  
20 under title XVIII of the Social Security Act (42  
21 U.S.C. 1395 et seq.) (in this section referred to as  
22 the “medicare program”) as such process applies to  
23 physicians, including the proper level of resources  
24 that the Health Care Financing Administration  
25 should devote to educating physicians regarding—

- 1 (A) coding and billing;
- 2 (B) documentation requirements; and
- 3 (C) the calculation of overpayments.

4 (2) REPORT.—Not later than 18 months after  
5 the date of enactment of this Act, the Comptroller  
6 General shall submit a report to the Secretary of  
7 Health and Human Services and Congress on the  
8 study conducted under paragraph (1) together with  
9 specific recommendations for changes or improve-  
10 ments in the post-payment audit process described  
11 in such paragraph.

12 (b) GAO STUDY ON ADMINISTRATION AND OVER-  
13 SIGHT.—

14 (1) STUDY.—The Comptroller General of the  
15 United States shall conduct a study on the aggre-  
16 gate effects of regulatory, audit, oversight, and pa-  
17 perwork burdens on physicians and other health care  
18 providers participating in the medicare program.

19 (2) REPORT.—Not later than 18 months after  
20 the date of enactment of this Act, the Comptroller  
21 General shall submit a report to the Secretary of  
22 Health and Human Services and Congress on the  
23 study conducted under paragraph (1) together with  
24 recommendations regarding any area in which—

1 (A) a reduction in paperwork, an ease of  
2 administration, or an appropriate change in  
3 oversight and review may be accomplished; or

4 (B) additional payments or education are  
5 needed to assist physicians and other health  
6 care providers in understanding and complying  
7 with any legal or regulatory requirements.

8 **SEC. 413. GAO STUDY ON GASTROINTESTINAL ENDOSCOPIC**  
9 **SERVICES FURNISHED IN PHYSICIANS' OF-**  
10 **FICES AND HOSPITAL OUTPATIENT DEPART-**  
11 **MENT SERVICES.**

12 (a) STUDY.—The Comptroller General of the United  
13 States shall conduct a study on the appropriateness of fur-  
14 nishing gastrointestinal endoscopic physicians' services in  
15 physicians' offices. In conducting this study, the Comp-  
16 troller General shall—

17 (1) review available scientific and clinical evi-  
18 dence regarding the safety of performing procedures  
19 in physicians' offices and hospital outpatient depart-  
20 ments;

21 (2) assess whether resource-based practice ex-  
22 pense relative values established by the Secretary of  
23 Health and Human Services under the medicare  
24 physician fee schedule under section 1848 of the So-  
25 cial Security Act (42 U.S.C. 1395w-4) for gastro-

1 intestinal endoscopic services furnished in physi-  
 2 cians' offices and hospital outpatient departments  
 3 create an incentive to furnish such services in physi-  
 4 cians' offices instead of hospital outpatient depart-  
 5 ments; and

6 (3) assess the implications for access to care for  
 7 medicare beneficiaries if gastrointestinal endoscopic  
 8 services in physicians' offices were not covered under  
 9 the medicare program.

10 (b) REPORT.—Not later than July 1, 2002, the  
 11 Comptroller General of the United States shall submit a  
 12 report to the Secretary of Health and Human Services and  
 13 Congress on the study conducted under subsection (a) to-  
 14 gether with such recommendations for legislation and ad-  
 15 ministrative action as the Comptroller General determines  
 16 appropriate.

## 17 **Subtitle C—Ambulance Services**

### 18 **SEC. 421. ELIMINATION OF REDUCTION IN INFLATION AD-** 19 **JUSTMENTS FOR AMBULANCE SERVICES.**

20 Subparagraphs (A) and (B) of section 1834(l)(3) (42  
 21 U.S.C. 1395m(l)(3)(A)) are each amended by striking “re-  
 22 duced in the case of 2001 and 2002 by 1.0 percentage  
 23 points” and inserting “increased in the case of 2001 by  
 24 1.0 percentage point”.

1 **SEC. 422. ELECTION TO FOREGO PHASE-IN OF FEE SCHED-**  
 2 **ULE FOR AMBULANCE SERVICES.**

3 Section 1834(l) (42 U.S.C. 1395m(l)) is amended by  
 4 adding at the end the following new paragraph:

5 “(8) ELECTION TO FOREGO PHASE-IN OF FEE  
 6 SCHEDULE.—

7 “(A) IN GENERAL.—If the Secretary pro-  
 8 vides for a phase-in of the fee schedule estab-  
 9 lished under this subsection, a supplier of am-  
 10 bulance services may make an election to re-  
 11 ceive payments at any time during such phase-  
 12 in based only on such fee schedule as in effect  
 13 after such phase-in, and the Secretary shall  
 14 begin to make payments to the supplier based  
 15 only on such fee schedule not later than the  
 16 date that is 60 days after the date on which the  
 17 supplier notifies the Secretary of such election.

18 “(B) WAIVER OF BUDGET NEUTRALITY.—  
 19 The Secretary shall apply paragraph (3)(A) as  
 20 if this paragraph had not been enacted.”.

21 **SEC. 423. STUDY AND REPORT ON THE COSTS OF RURAL**  
 22 **AMBULANCE SERVICES.**

23 (a) STUDY.—The Secretary of Health and Human  
 24 Services (in this section referred to as the “Secretary”),  
 25 in consultation with the Office of Rural Health Policy,  
 26 shall conduct a study on the means by which rural areas

1 with low population densities can be identified for the pur-  
2 pose of designating areas in which the cost of providing  
3 ambulance services would be expected to be higher than  
4 similar services provided in more heavily populated areas  
5 because of low usage. Such study shall also include an  
6 analysis of the additional costs of providing ambulance  
7 services in areas designated under the previous sentence.

8 (b) REPORT.—Not later than June 30, 2001, the  
9 Secretary shall submit a report to Congress on the study  
10 conducted under subsection (a), together with a regulation  
11 based on that study which adjusts the fee schedule pay-  
12 ment rates for ambulance services provided in low density  
13 rural areas based on the increased cost of providing such  
14 services in such areas.

15 **SEC. 424. GAO STUDY AND REPORT ON THE COSTS OF**  
16 **EMERGENCY AND MEDICAL TRANSPOR-**  
17 **TATION SERVICES.**

18 (a) STUDY.—The Comptroller General of the United  
19 States shall conduct a study on the costs of providing  
20 emergency and medical transportation services across the  
21 range of acuity levels of conditions for which such trans-  
22 portation services are provided.

23 (b) REPORT.—Not later than 18 months after the  
24 date of enactment of this Act, the Comptroller General  
25 shall submit a report to the Secretary of Health and

1 Human Services and Congress on the study conducted  
 2 under subsection (a), together with recommendations for  
 3 any changes in methodology or payment level necessary  
 4 to fairly compensate suppliers of emergency and medical  
 5 transportation services and to ensure the access of bene-  
 6 ficiaries under the medicare program under title XVIII of  
 7 the Social Security Act (42 U.S.C. 1395 et seq.) to such  
 8 services.

## 9 **Subtitle D—Other Services**

### 10 **SEC. 431. REVISION OF MORATORIUM IN CAPS FOR THER-** 11 **APY SERVICES.**

12 (a) EXTENSION OF MORATORIUM.—Section  
 13 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by strik-  
 14 ing “during 2000 and 2001” and inserting “during the  
 15 period beginning on January 1, 2000, and ending on the  
 16 date that is 18 months after the date on which the Sec-  
 17 retary submits the report required under section  
 18 4541(d)(2) of the Balanced Budget Act of 1997 to Con-  
 19 gress”.

20 (b) EXTENSION OF REPORTING DATE.—Section  
 21 4541(d)(2) of BBA (42 U.S.C. 1395l note), as amended  
 22 by section 221(c) of BBRA (113 Stat. 1501A–351), is  
 23 amended by striking “January 1, 2001” and inserting  
 24 “January 1, 2002” in the matter preceding subparagraph  
 25 (A).

1 **SEC. 432. UPDATE IN RENAL DIALYSIS COMPOSITE RATE.**

2       The last sentence of section 1881(b)(7) (42 U.S.C.  
3 1395rr(b)(7)) is amended by striking “for such services  
4 furnished on or after January 1, 2001, by 1.2 percent”  
5 and inserting “for such services furnished on or after Jan-  
6 uary 1, 2001, by 2.4 percent”.

7 **SEC. 433. FULL UPDATE IN 2001 FOR DURABLE MEDICAL**  
8 **EQUIPMENT, OXYGEN, AND OXYGEN EQUIP-**  
9 **MENT.**

10       (a) **UPDATE FOR COVERED ITEMS.**—Section  
11 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

12           (1) by redesignating subparagraph (D) as sub-  
13 paragraph (F);

14           (2) in subparagraph (C)—

15               (A) by striking “through 2002” and insert-  
16 ing “through 2000”; and

17               (B) by striking “ and” at the end; and

18           (3) by inserting after subparagraph (C) the fol-  
19 lowing new subparagraphs:

20               “(D) for 2001, the percentage increase in  
21 the consumer price index for all urban con-  
22 sumers (U.S. urban average) for the 12-month  
23 period ending with June 2000;

24               “(E) for 2002, 0 percentage points; and”.

25       (b) **ORTHOTICS AND PROSTHETICS.**—Section  
26 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—



1 (1) by redesignating clause (vi) as clause (viii);

2 (2) in clause (v)—

3 (A) by striking “through 2002” and insert-  
4 ing “through 2000”; and

5 (B) by striking “ and” at the end; and

6 (3) by inserting after clause (v) the following  
7 new clauses:

8 “(vi) for 2001, the percentage in-  
9 crease in the consumer price index for all  
10 urban consumers (United States City aver-  
11 age) for the 12-month period ending with  
12 June 2000;

13 “(vi) for 2002, 1 percent; and”.

14 (c) PARENTERAL AND ENTERAL NUTRIENTS, SUP-  
15 PLIES, AND EQUIPMENT.—Section 4551(b) of BBA (42  
16 U.S.C. 1395m note) is amended by striking “through  
17 2002” and inserting “, 1999, 2000, and 2002”.

18 (d) OXYGEN AND OXYGEN EQUIPMENT.—Section  
19 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

20 (1) in clause (v), by striking “and” at the end;

21 (2) in clause (vi)—

22 (A) by striking “each subsequent year”  
23 and inserting “2000”; and

24 (B) by striking the period at the end and  
25 inserting a semicolon; and

1           (3) by adding at the end the following new  
2       clauses:

3                   “(vii) for 2001, the amount deter-  
4                   mined under this subparagraph for 2000  
5                   increased by the covered item update for  
6                   2001;

7                   “(viii) for 2002, 70 percent of the  
8                   amount determined under this subpara-  
9                   graph for 1997; and

10                  “(ix) for 2003 and each subsequent  
11                  year, the amount determined under this  
12                  subparagraph for the preceding year in-  
13                  creased by the covered item update for  
14                  such subsequent year.”.

15       (e) CONFORMING AMENDMENT.—Section 228 of  
16 BBRA (113 Stat. 1501A–356) is repealed.

17 **SEC. 434. NATIONAL LIMITATION AMOUNT EQUAL TO 100**  
18 **PERCENT OF NATIONAL MEDIAN FOR NEW**  
19 **PAP SMEAR TECHNOLOGIES AND OTHER NEW**  
20 **CLINICAL LABORATORY TEST TECH-**  
21 **NOLOGIES.**

22       Section 1833(h)(4)(B)(viii) (42 U.S.C.  
23 1395l(h)(4)(B)(viii)) is amended by inserting before the  
24 period at the end the following: “(or 100 percent of such  
25 median in the case of a clinical diagnostic laboratory test

1 performed on or after January 1, 2001, that the Secretary  
 2 determines is a new test for which no limitation amount  
 3 has previously been established under this subpara-  
 4 graph)''.

5 **SEC. 435. DELAY AND REVISION OF PPS FOR AMBULATORY**  
 6 **SURGICAL CENTERS.**

7 (a) DELAY IN IMPLEMENTATION OF PROSPECTIVE  
 8 PAYMENT SYSTEM.—The Secretary of Health and Human  
 9 Services may not implement a revised prospective payment  
 10 system for services of ambulatory surgical facilities under  
 11 section 1833(i) of the Social Security Act (42 U.S.C.  
 12 1395l(i)) before January 1, 2002.

13 (b) EXTENDING PHASE-IN TO 4 YEARS.—Section  
 14 226 of the BBRA (113 Stat. 1501A–354) is amended by  
 15 striking paragraphs (1) and (2) and inserting the fol-  
 16 lowing:

17 “(1) in the first year of its implementation,  
 18 only a proportion (specified by the Secretary and not  
 19 to exceed  $\frac{1}{4}$ ) of the payment for such services shall  
 20 be made in accordance with such system and the re-  
 21 mainder shall be made in accordance with current  
 22 regulations; and

23 “(2) in each of the following 2 years a propor-  
 24 tion (specified by the Secretary and not to exceed  
 25  $\frac{1}{2}$ , and  $\frac{3}{4}$ , respectively) of the payment for such

1 services shall be made under such system and the  
 2 remainder shall be made in accordance with current  
 3 regulations.”.

4 (c) DEADLINE FOR USE OF 1999 OR LATER COST  
 5 SURVEYS.—Section 226 of BBRA (113 Stat. 1501A–354)  
 6 is amended by adding at the end the following:  
 7 “By not later than January 1, 2003, the Secretary shall  
 8 incorporate data from a 1999 Medicare cost survey or a  
 9 subsequent cost survey for purposes of implementing or  
 10 revising such system.”.

11 **SEC. 436. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY**  
 12 **SERVICES.**

13 (a) IN GENERAL.—Section 1848(i) (42 U.S.C.  
 14 1395w–4(i)) is amended by adding at the end the fol-  
 15 lowing new paragraph:

16 “(4) TREATMENT OF CERTAIN PHYSICIAN PA-  
 17 THOLOGY SERVICES.—

18 “(A) IN GENERAL.—Notwithstanding any  
 19 other provision of law, when an independent  
 20 laboratory furnishes the technical component of  
 21 a physician pathology service with respect to a  
 22 fee-for-service medicare beneficiary who is a pa-  
 23 tient of a grandfathered hospital, such compo-  
 24 nent shall be treated as a service for which pay-

ment shall be made to the laboratory under this section and not as—

“(i) an inpatient hospital service for which payment is made to the hospital under section 1886(d); or

“(ii) a hospital outpatient service for which payment is made to the hospital under the prospective payment system under section 1834(t).

“(B) DEFINITIONS.—In this paragraph:

“(i) GRANDFATHERED HOSPITAL.—The term ‘grandfathered hospital’ means a hospital that had an arrangement with an independent laboratory—

“(I) that was in effect as of July 22, 1999; and

“(II) under which the laboratory furnished the technical component of physician pathology services with respect to patients of the hospital and submitted a claim for payment for such component to a carrier with a contract under section 1842 (and not to the hospital).

1                   “(ii) FEE-FOR-SERVICE MEDICARE  
 2                   BENEFICIARY.—The term ‘fee-for-service  
 3                   medicare beneficiary’ means an individual  
 4                   who is not enrolled—

5                   “(I) in a Medicare+Choice plan  
 6                   under part C;

7                   “(II) in a plan offered by an eli-  
 8                   gible organization under section 1876;

9                   “(III) with a PACE provider  
 10                  under section 1894;

11                  “(IV) in a medicare managed  
 12                  care demonstration project; or

13                  “(V) in the case of a service fur-  
 14                  nished to an individual on an out-  
 15                  patient basis, in a health care prepay-  
 16                  ment plan under section  
 17                  1833(a)(1)(A).”.

18           (b) EFFECTIVE DATE.—The amendment made by  
 19 this section shall apply to services furnished on or after  
 20 January 1, 2001.

21 **SEC. 437. MODIFICATION OF MEDICARE BILLING REQUIRE-**  
 22 **MENTS FOR CERTAIN INDIAN PROVIDERS.**

23           (a) IN GENERAL.—Section 1880(a) (42 U.S.C.  
 24 1395qq(a)) is amended by adding at the end the following  
 25 new sentence: “A hospital or a free-standing ambulatory

1 care clinic (as defined by the Secretary), whether operated  
 2 by the Indian Health Service or by an Indian tribe or trib-  
 3 al organization (as those terms are defined in section 4  
 4 of the Indian Health Care Improvement Act), shall be eli-  
 5 gible for payments for services for which payment is made  
 6 pursuant to section 1848, notwithstanding sections  
 7 1814(c) and 1835(d), if and for so long as it meets all  
 8 of the requirements which are applicable generally to such  
 9 payments, services, hospitals, and clinics.”.

10 (b) EFFECTIVE DATE.—The amendments made by  
 11 this section shall apply to services furnished on or after  
 12 January 1, 2001.

13 **SEC. 438. REPLACEMENT OF PROSTHETIC DEVICES AND**  
 14 **PARTS.**

15 (a) IN GENERAL.—Section 1834(h)(1) of the Social  
 16 Security Act (42 U.S.C. 1395m(h)(1)) is amended by add-  
 17 ing at the end the following new subparagraph:

18 “(F) REPLACEMENT OF PROSTHETIC DE-  
 19 VICES AND PARTS.—

20 “(i) IN GENERAL.—Payment shall be  
 21 made for the replacement of prosthetic de-  
 22 vices which are artificial limbs, or for the  
 23 replacement of any part of such devices,  
 24 without regard to continuous use or useful  
 25 lifetime restrictions if an ordering physi-

1           cian determines that the provision of a re-  
2           placement device, or a replacement part of  
3           such a device, is necessary because of any  
4           of the following:

5                   “(I) A change in the physio-  
6                   logical condition of the patient.

7                   “(II) An irreparable change in  
8                   the condition of the device, or in a  
9                   part of the device.

10                  “(III) The condition of the de-  
11                  vice, or the part of the device, re-  
12                  quires repairs and the cost of such re-  
13                  pairs would be more than 60 percent  
14                  of the cost of a replacement device, or,  
15                  as the case may be, of the part being  
16                  replaced.

17                  “(ii) CONFIRMATION MAY BE RE-  
18                  QUIRED IF REPLACEMENT DEVICE OR  
19                  PART IS LESS THAN 2 YEARS OLD.—If a  
20                  physician determines that a replacement  
21                  device, or a replacement part, is necessary  
22                  pursuant to clause (i)—

23                   “(I) such determination shall be  
24                   controlling; and



1                   “(II) such replacement device or  
2                   part shall be deemed to be reasonable  
3                   and necessary for purposes of section  
4                   1862(a)(1)(A);  
5                   except that if the device, or part, being re-  
6                   placed is less than 2 years old (calculated  
7                   from the date on which the beneficiary  
8                   began to use the device or part), the Sec-  
9                   retary may also require the beneficiary to  
10                  provide confirmation of necessity of the re-  
11                  placement device, or, as the case may be,  
12                  the replacement part, by a prosthetist se-  
13                  lected by the beneficiary.”.

14           (b) PREEMPTION OF RULE.—The provisions of sec-  
15   tion 1834(h)(1)(F) of the Social Security Act (42 U.S.C.  
16   1395m(h)(1)(F)), as added by subsection (a), shall super-  
17   sede any rule that as of the date of enactment of this Act  
18   may have applied a 5-year replacement rule with regard  
19   to prosthetic devices.

20           (c) EFFECTIVE DATE.—The amendment made by  
21   subsection (a) shall apply to items furnished on or after  
22   the date of enactment of this Act.

1 **SEC. 439. MEDPAC STUDY AND REPORT ON MEDICARE RE-**  
2 **IMBURSEMENT FOR SERVICES PROVIDED BY**  
3 **CERTAIN PROVIDERS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-  
5 mission (referred to in this section as “MedPAC”) shall  
6 conduct a study on the appropriateness of the current pay-  
7 ment rates under the medicare program under title XVIII  
8 of the Social Security Act (42 U.S.C. 1395 et seq.) for  
9 services provided by a—

10 (1) certified nurse-midwife (as defined in sub-  
11 section (gg)(2) of section 1861 of the Social Security  
12 Act (42 U.S.C. 1395x);

13 (2) physician assistant (as defined in subsection  
14 (aa)(5)(A) of such section);

15 (3) nurse practitioner (as defined in such sub-  
16 section); and

17 (4) clinical nurse specialist (as defined in sub-  
18 section (aa)(5)(B) of such section).

19 (b) REPORT.—Not later than 18 months after the  
20 date of enactment of this Act, MedPAC shall submit a  
21 report to the Secretary of Health and Human Services and  
22 Congress on the study conducted under subsection (a), to-  
23 gether with any recommendations for legislation that  
24 MedPAC determines to be appropriate as a result of such  
25 study.

1 **SEC. 440. MEDPAC STUDY AND REPORT ON MEDICARE COV-**  
2 **ERAGE OF SERVICES PROVIDED BY CERTAIN**  
3 **NON-PHYSICIAN PROVIDERS.**

4 (a) STUDY.—

5 (1) IN GENERAL.—The Medicare Payment Ad-  
6 visory Commission (referred to in this section as  
7 “MedPAC”) shall conduct a study to determine the  
8 appropriateness of providing coverage under the  
9 medicare program under title XVIII of the Social  
10 Security Act (42 U.S.C. 1395 et seq.) for services  
11 provided by a—

- 12 (A) certified first nurse assistant;  
13 (B) marriage counselor;  
14 (C) pastoral care counselor; and  
15 (D) licensed professional counselor of men-  
16 tal health.

17 (2) COSTS TO PROGRAM.—The study shall con-  
18 sider the short-term and long-term benefits, and  
19 costs to the medicare program, of providing the cov-  
20 erage described in paragraph (1).

21 (b) REPORT.—Not later than 18 months after the  
22 date of enactment of this Act, MedPAC shall submit a  
23 report to the Secretary of Health and Human Services and  
24 Congress on the study conducted under subsection (a), to-  
25 gether with any recommendations for legislation that

1 MedPAC determines to be appropriate as a result of such  
2 study.

3 **TITLE V—PROVISIONS**  
4 **RELATING TO PARTS A AND B**  
5 **Subtitle A—Home Health Services**

6 **SEC. 501. 1-YEAR ADDITIONAL DELAY IN APPLICATION OF**  
7 **15 PERCENT REDUCTION ON PAYMENT LIM-**  
8 **ITS FOR HOME HEALTH SERVICES.**

9 (a) IN GENERAL.—Section 1895(b)(3)(A)(i) (42  
10 U.S.C. 1395fff(b)(3)(A)(i)) is amended—

11 (1) by redesignating subclause (II) as subclause  
12 (III);

13 (2) in subclause (III), as redesignated, by strik-  
14 ing “described in subclause (I)” and inserting “de-  
15 scribed in subclause (II)”;

16 (3) by inserting after subclause (I) the fol-  
17 lowing new subclause:

18 “(II) For the 12-month period  
19 beginning after the period described  
20 in subclause (I), such amount (or  
21 amounts) shall be equal to the amount  
22 (or amounts) determined under sub-  
23 clause (I), updated under subpara-  
24 graph (B).”.

1 (b) CHANGE IN REPORT.—Section 302(c) of BBRA  
 2 is amended by striking “Not later than” and all that fol-  
 3 lows through “(42 U.S.C. 1395fff)” and inserting “Not  
 4 later than October 1, 2001”.

5 **SEC. 502. RESTORATION OF FULL HOME HEALTH MARKET**  
 6 **BASKET UPDATE FOR HOME HEALTH SERV-**  
 7 **ICES FOR FISCAL YEAR 2001.**

8 (a) IN GENERAL.—Section 1861(v)(1)(L)(x) (42  
 9 U.S.C. 1395x(v)(1)(L)(x)) is amended—

10 (1) by striking “2001,”; and

11 (2) by adding at the end the following: “With  
 12 respect to cost reporting periods beginning during  
 13 fiscal year 2001, the update to any limit under this  
 14 subparagraph shall be the home health market bas-  
 15 ket index.”.

16 (b) SPECIAL RULE FOR PAYMENT FOR FISCAL YEAR  
 17 2001 BASED ON ADJUSTED PROSPECTIVE PAYMENT  
 18 AMOUNTS.—

19 (1) IN GENERAL.—Notwithstanding the amend-  
 20 ments made by subsection (a), for purposes of mak-  
 21 ing payments under section 1895(b) of the Social  
 22 Security Act (42 U.S.C. 1395fff(b)) for home health  
 23 services for fiscal year 2001, the Secretary of Health  
 24 and Human Services shall—

1 (A) with respect to episodes and visits end-  
2 ing on or after October 1, 2000, and before  
3 April 1, 2001, use the final standardized and  
4 budget neutral prospective payment amounts  
5 for 60 day episodes and standardized average  
6 per visit amounts for fiscal year 2001 as pub-  
7 lished by the Secretary in Federal Register of  
8 the July 3, 2000 (65 Federal Register 41128–  
9 41214); and

10 (B) with respect to episodes and visits end-  
11 ing on or after April 1, 2001, and before Octo-  
12 ber 1, 2001, use such amounts increased by an  
13 actuarially determined amount that represents  
14 the different distributions of episodes and visits  
15 in the first and second 6 month periods of fiscal  
16 year 2001 due to implementation of the home  
17 health prospective payment system under sec-  
18 tion 1895 of such Act (42 U.S.C. 1395fff).

19 (2) NO EFFECT ON OTHER PAYMENTS OR DE-  
20 TERMINATIONS.—The Secretary shall not take the  
21 provisions of paragraph (1) into account for pur-  
22 poses of payments, determinations, or budget neu-  
23 trality adjustments under section 1895 of the Social  
24 Security Act.

25 (c) ADJUSTMENT FOR CASE MIX CHANGES.—

1           (1) IN GENERAL.—Section 1895(b)(3)(B) (42  
2       U.S.C. 1395fff(b)(3)(B)) is amended by adding at  
3       the end the following new clause:

4                       “(vi) ADJUSTMENT FOR CASE MIX  
5           CHANGES.—Insofar as the Secretary deter-  
6           mines that the adjustments under para-  
7           graph (4)(A)(i) for a previous fiscal year  
8           (or estimates that such adjustments for a  
9           future fiscal year) did (or are likely to) re-  
10          sult in a change in aggregate payments  
11          under this subsection during the fiscal year  
12          that are a result of changes in the coding  
13          or classification of different units of serv-  
14          ices that do not reflect real changes in case  
15          mix, the Secretary may adjust the stand-  
16          ard prospective payment amount (or  
17          amounts) under paragraph (3) for subse-  
18          quent fiscal years so as to eliminate the ef-  
19          fect of such coding or classification  
20          changes.”.

21           (2) EFFECTIVE DATE.—The amendment made  
22       by paragraph (1) applies to episodes concluding on  
23       or after October 1, 2001.

1 **SEC. 503. EXCLUSION OF CERTAIN NONROUTINE MEDICAL**  
2 **SUPPLIES UNDER THE PPS FOR HOME**  
3 **HEALTH SERVICES.**

4 (a) EXCLUSION.—

5 (1) IN GENERAL.—Section 1895 (42 U.S.C.  
6 1395fff) is amended by adding at the end the fol-  
7 lowing new subsection:

8 “(e) EXCLUSION OF NONROUTINE MEDICAL SUP-  
9 PLIES.—

10 “(1) IN GENERAL.—Notwithstanding the pre-  
11 ceding provisions of this section, in the case of all  
12 nonroutine medical supplies (as defined by the Sec-  
13 retary) furnished by a home health agency during a  
14 year (beginning with 2001) for which payment is  
15 otherwise made on the basis of the prospective pay-  
16 ment amount under this section, payment under this  
17 section shall be based instead on the lesser of—

18 “(A) the actual charge for the nonroutine  
19 medical supply; or

20 “(B) the amount determined under the fee  
21 schedule established by the Secretary for pur-  
22 poses of making payment for such items under  
23 part B for nonroutine medical supplies fur-  
24 nished during that year.

25 “(2) BUDGET NEUTRALITY ADJUSTMENT.—The  
26 Secretary shall provide for an appropriate propor-



1 tional reduction in payments under this section so  
 2 that, beginning with fiscal year 2001, the aggregate  
 3 amount of such reductions is equal to the aggregate  
 4 increase in payments attributable to the exclusion ef-  
 5 fected under paragraph (1).”.

6 (2) CONFORMING AMENDMENT.—Section  
 7 1895(b)(1) of the Social Security Act (42 U.S.C.  
 8 1395fff(b)(1)) is amended by striking “The Sec-  
 9 retary” and inserting “Subject to subsection (e), the  
 10 Secretary”.

11 (3) EFFECTIVE DATE.—The amendments made  
 12 by this subsection shall apply to supplies furnished  
 13 on or after January 1, 2001.

14 (b) EXCLUSION FROM CONSOLIDATED BILLING.—

15 (1) IN GENERAL.—For items provided during  
 16 the applicable period, the Secretary of Health and  
 17 Human Services shall administer the medicare pro-  
 18 gram under title XVIII of the Social Security Act  
 19 (42 U.S.C. 1395 et seq.) as if—

20 (A) section 1842(b)(6)(F) of such Act (42  
 21 U.S.C. 1395u(b)(6)(F)) was amended by strik-  
 22 ing “(including medical supplies described in  
 23 section 1861(m)(5), but excluding durable med-  
 24 ical equipment to the extent provided for in  
 25 such section)” and inserting “(excluding med-

1           ical supplies and durable medical equipment de-  
2           scribed in section 1861(m)(5))”; and

3                   (B) section 1862(a)(21) of such Act (42  
4           U.S.C. 1395y(a)(21)) was amended by striking  
5           “(including medical supplies described in sec-  
6           tion 1861(m)(5), but excluding durable medical  
7           equipment to the extent provided for in such  
8           section)” and inserting “(excluding medical  
9           supplies and durable medical equipment de-  
10          scribed in section 1861(m)(5))”.

11          (2) APPLICABLE PERIOD DEFINED.—For pur-  
12          poses of paragraph (1), the term “applicable period”  
13          means the period beginning on January 1, 2001,  
14          and ending on the later of—

15                   (A) the date that is 18 months after the  
16                  date of enactment of this Act; or

17                   (B) the date determined appropriate by the  
18                  Secretary of Health and Human Services.

19          (c) STUDY ON EXCLUSION OF CERTAIN NONROUTINE  
20          MEDICAL SUPPLIES UNDER THE PPS FOR HOME  
21          HEALTH SERVICES.—

22                   (1) STUDY.—The Secretary of Health and  
23          Human Services (in this subsection referred to as  
24          the “Secretary”) shall conduct a study to identify  
25          any nonroutine medical supply that may be appro-

1       priately and cost-effectively excluded from the pro-  
2       spective payment system for home health services  
3       under section 1895 of the Social Security Act (42  
4       U.S.C. 1395fff). Specifically, the Secretary shall  
5       consider whether wound care and ostomy supplies  
6       should be excluded from such prospective payment  
7       system.

8           (2) REPORT.—Not later than 18 months after  
9       the date of enactment of this Act, the Secretary  
10      shall submit to Congress a report on the study con-  
11      ducted under paragraph (1), including a list of any  
12      nonroutine medical supplies that should be excluded  
13      from the prospective payment system for home  
14      health services under section 1895 of the Social Se-  
15      curity Act (42 U.S.C. 1395fff).

16      (d) EXCLUSION OF OTHER NONROUTINE MEDICAL  
17      SUPPLIES.—Upon submission of the report under sub-  
18      section (c)(2), the Secretary shall (if necessary) revise the  
19      definition of nonroutine medical supply, as defined for  
20      purposes of section 1895(e) (as added by subsection (a)),  
21      based on the list of nonroutine medical supplies included  
22      in such report.

1 **SEC. 504. TREATMENT OF BRANCH OFFICES; GAO STUDY**  
2 **ON SUPERVISION OF HOME HEALTH CARE**  
3 **PROVIDED IN ISOLATED RURAL AREAS.**

4 (a) TREATMENT OF BRANCH OFFICES.—

5 (1) IN GENERAL.—Notwithstanding any other  
6 provision of law, in determining for purposes of title  
7 XVIII of the Social Security Act whether an office  
8 of a home health agency constitutes a branch office  
9 or a separate home health agency, neither the time  
10 nor distance between a parent office of the home  
11 health agency and a branch office shall be the sole  
12 determinant of a home health agency's branch office  
13 status.

14 (2) CONSIDERATION OF FORMS OF TECH-  
15 NOLOGY IN DEFINITION OF SUPERVISION.—The Sec-  
16 retary of Health and Human Services may include  
17 forms of technology in determining what constitutes  
18 “supervision” for purposes of determining a home  
19 heath agency's branch office status under paragraph  
20 (1).

21 (b) GAO STUDY.—

22 (1) STUDY.—The Comptroller General of the  
23 United States shall conduct a study of the provision  
24 of adequate supervision to maintain quality of home  
25 health services delivered under the medicare pro-  
26 gram in isolated rural areas. The study shall evalu-

1        ate the methods that home health agency branches  
 2        and subunits use to maintain adequate supervision  
 3        in the delivery of services to clients residing in those  
 4        areas, how these methods of supervision compare to  
 5        requirements that subunits independently meet  
 6        medicare conditions of participation, and the re-  
 7        sources utilized by subunits to meet such conditions.

8            (2) REPORT.—Not later than January 1, 2002,  
 9        the Comptroller General shall submit to Congress a  
 10       report on the study conducted under paragraph (1).  
 11       The report shall include recommendations on wheth-  
 12       er exceptions are needed for subunits and branches  
 13       of home health agencies under the medicare program  
 14       to maintain access to the home health benefit or  
 15       whether alternative policies should be developed to  
 16       assure adequate supervision and access and rec-  
 17       ommendations on whether a national standard for  
 18       supervision is appropriate.

19    **SEC. 505. TEMPORARY ADDITIONAL PAYMENTS FOR HIGH-**  
 20                            **COST PATIENTS.**

21        (a) INCREASE FOR FISCAL YEARS 2001 AND 2002.—  
 22       For each of fiscal years 2001 and 2002, the Secretary of  
 23       Health and Human Services shall increase the addition  
 24       or adjustment for outliers under section 1895(b)(5) of the  
 25       Social Security Act (42 U.S.C. 1395fff(b)(5)) applicable

1 to home health services furnished during a fiscal year by  
2 such proportion as will result in an aggregate increase in  
3 such addition or adjustment for the fiscal year estimated  
4 to equal \$150,000,000.

5 (b) ADDITIONAL PAYMENT NOT BUILT INTO THE  
6 BASE.—The Secretary of Health and Human Services  
7 shall not include any additional payment made under sub-  
8 section (a) in updating the standard prospective payment  
9 amount (or amounts) applicable to units of home health  
10 services furnished during a period, as increased by the  
11 home health applicable increase percentage for the fiscal  
12 year involved under section 1895(b)(3)(B) of the Social  
13 Security Act (42 U.S.C. 1395fff(b)(3)(B)).

14 (c) WAIVING BUDGET NEUTRALITY.—The Secretary  
15 of Health and Human Services shall not reduce the stand-  
16 ard prospective payment amount (or amounts) under sec-  
17 tion 1895 of the Social Security Act (42 U.S.C. 1395fff),  
18 including under subsection (b)(3)(C) of such Act, applica-  
19 ble to units of home health services furnished during a  
20 period to offset the increase in payments resulting from  
21 the application of subsection (a).

1 **SEC. 506. CLARIFICATION OF THE HOMEBOUND DEFINI-**  
2 **TION UNDER THE MEDICARE HOME HEALTH**  
3 **BENEFIT.**

4 (a) IN GENERAL.—Sections 1814(a) and 1835(a) (42  
5 U.S.C. 1395f(a) and 1395n(a)) are each amended—

6 (1) in the last sentence, by striking “, and that  
7 absences of the individual from home are infrequent  
8 or of relatively short duration, or are attributable to  
9 the need to receive medical treatment”; and

10 (2) by adding at the end the following new sen-  
11 tences: “Any absence of an individual from the home  
12 attributable to the need to receive health care treat-  
13 ment, including regular absences for the purpose of  
14 participating in therapeutic, psychosocial, or medical  
15 treatment in an adult day-care program that is li-  
16 censed or certified by a State, or accredited, to fur-  
17 nish adult day-care services in the State shall not  
18 disqualify an individual from being considered to be  
19 ‘confined to his home’. Any other absence of an indi-  
20 vidual from the home shall not so disqualify an indi-  
21 vidual if the absence is of infrequent or short dura-  
22 tion. For purposes of the preceding sentence, any  
23 absence for the purpose of visiting a family member  
24 who is unable to visit the individual or for the pur-  
25 pose of attending a religious service shall be deemed  
26 to be an absence of infrequent and short duration.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall apply to items and services provided  
3 on or after the date of enactment of this Act.

4 **Subtitle B—Direct Graduate**  
5 **Medical Education**

6 **SEC. 511. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**  
7 **CLINICAL PSYCHOLOGISTS IN PAYMENTS TO**  
8 **HOSPITALS.**

9 Effective for cost reporting periods beginning on or  
10 after October 1, 1999, for purposes of payments to hos-  
11 pitals under the medicare program under title XVIII of  
12 the Social Security Act (42 U.S.C. 1395 et seq.) for costs  
13 of approved educational activities (as defined in section  
14 413.85 of title 42 of the Code of Federal Regulations),  
15 such approved educational activities shall include the clin-  
16 ical portion of professional educational training programs,  
17 recognized by the Secretary, for clinical psychologists.



1 **TITLE VI—PROVISIONS RELAT-**  
 2 **ING TO PART C**  
 3 **(MEDICARE+CHOICE PRO-**  
 4 **GRAM) AND OTHER MEDI-**  
 5 **CARE MANAGED CARE PROVI-**  
 6 **SIONS**

7 **Subtitle A—Medicare+Choice**  
 8 **Payment Reforms**

9 **SEC. 601. INCREASE IN NATIONAL PER CAPITA**  
 10 **MEDICARE+CHOICE GROWTH PERCENTAGE**  
 11 **IN 2001 AND 2002.**

12 Section 1853(c)(6)(B) (42 U.S.C. 1395w–  
 13 23(c)(6)(B)) is amended—

14 (1) in clause (iv), by striking “for 2001, 0.5  
 15 percentage points” and inserting “for 2001, 0 per-  
 16 centage points”; and

17 (2) in clause (v), by striking “for 2002, 0.3 per-  
 18 centage points” and inserting “for 2002, 0 percent-  
 19 age points”.

20 **SEC. 602. REMOVING APPLICATION OF BUDGET NEU-**  
 21 **TRALITY FOR 2002.**

22 Section 1853(c) (42 U.S.C. 1395w–23(c)) is  
 23 amended—

1 (1) in paragraph (1)(A), in the matter following  
 2 clause (ii), by inserting “(except for 2002)” after  
 3 “multiplied”; and

4 (2) in paragraph (5), by inserting “(except for  
 5 2002)” after “for each year”.

6 **SEC. 603. INCREASE IN MINIMUM PAYMENT AMOUNT.**

7 Section 1853(c)(1)(B)(ii) (42 U.S.C. 1395w–  
 8 23(c)(1)(B)(ii)) is amended—

9 (1) by striking “(ii) For a succeeding year” and  
 10 inserting “(ii)(I) Subject to subclause (II), for a suc-  
 11 ceeding year”; and

12 (2) by adding at the end the following new sub-  
 13 clause:

14 “(II) For 2001 for any area in any  
 15 Metropolitan Statistical Area with a popu-  
 16 lation of more than 250,000, \$475 (and  
 17 for any area outside such an area, \$425).”.

18 **SEC. 604. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**  
 19 **IN 2002.**

20 Section 1853(c)(2) (42 U.S.C. 1395w–23(c)(2)) is  
 21 amended—

22 (1) by striking the period at the end of sub-  
 23 paragraph (F) and inserting a semicolon; and

24 (2) by adding after and below subparagraph  
 25 (F) the following:

1 “except that a Medicare+Choice organization may  
 2 elect to apply subparagraph (F) (rather than sub-  
 3 paragraph (E)) for 2002.”.

4 **SEC. 605. INCREASED UPDATE FOR PAYMENT AREAS WITH**  
 5 **ONLY ONE OR NO MEDICARE+CHOICE CON-**  
 6 **TRACTS.**

7 (a) IN GENERAL.—Section 1853(c)(1)(C)(ii) (42  
 8 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

9 (1) by striking “(ii) For a subsequent year”  
 10 and inserting “(ii)(I) Subject to subclause (II), for  
 11 a subsequent year”; and

12 (2) by adding at the end the following new sub-  
 13 clause:

14 “(II) During 2002 and 2003, in the  
 15 case of a Medicare+Choice payment area  
 16 in which there is no more than 1 contract  
 17 entered into under this part as of July 1  
 18 before the beginning of the year, 102.5  
 19 percent of the annual Medicare+Choice  
 20 capitation rate under this paragraph for  
 21 the area for the previous year.”.

22 (b) CONSTRUCTION.—The amendments made by sub-  
 23 section (a) shall not affect the payment of a first time  
 24 bonus under section 1853(i) of the Social Security Act (42  
 25 U.S.C. 1395w–23(i)).

1 **SEC. 606. 10-YEAR PHASE-IN OF RISK ADJUSTMENT AND**  
2 **NEW METHODOLOGY.**

3 Section 1853(a)(3)(C)(ii) (42 U.S.C. 1395w—  
4 23(c)(1)(C)(ii)) is amended—

5 (1) in subclause (I), by striking “and” at the  
6 end;

7 (2) in subclause (II), by striking “2002.” and  
8 inserting “2002 and 2003.”; and

9 (3) by adding at the end the following:

10 “(IV) 30 percent of such capita-  
11 tion rate in 2004 (in which such  
12 methodology should reflect a blend of  
13 20 percent of only data from inpatient  
14 settings and 10 percent of data from  
15 all settings);

16 “(V) 40 percent of such amount  
17 in 2005 (in which such methodology  
18 should reflect a blend of 10 percent of  
19 only data from inpatient settings and  
20 30 percent of data from all settings);

21 “(VI) 50 percent of such amount  
22 in 2006 (in which such methodology  
23 should reflect data from all settings);

24 “(VII) 60 percent of such  
25 amount in 2007 (in which such meth-

1                   odology should reflect data from all  
2                   settings);

3                   “(VIII) 70 percent of such  
4                   amount in 2008 (in which such meth-  
5                   odology should reflect data from all  
6                   settings);

7                   “(IX) 80 percent of such amount  
8                   in 2009 (in which such methodology  
9                   should reflect data from all settings);

10                  “(X) 90 percent of such amount  
11                  in 2010 (in which such methodology  
12                  should reflect data from all settings);  
13                  and

14                  “(XI) 100 percent of such  
15                  amount in any subsequent year (in  
16                  which such methodology should reflect  
17                  data from all settings).”.

18 **SEC. 607. PERMITTING PREMIUM REDUCTIONS AS ADDI-**  
19 **TIONAL BENEFITS UNDER**  
20 **MEDICARE+CHOICE PLANS.**

21       (a) IN GENERAL.—

22               (1) AUTHORIZATION OF PART B PREMIUM RE-  
23       DUCTIONS.—Section 1854(f)(1) (42 U.S.C. 1395w-  
24       24(f)(1)) is amended by adding at the end the fol-  
25       lowing new subparagraph:

1 “(F) PREMIUM REDUCTIONS.—

2 “(i) IN GENERAL.—Subject to clause  
3 (ii), as part of providing any additional  
4 benefits required under subparagraph (A),  
5 a Medicare+Choice organization may elect  
6 a reduction in its payments under section  
7 1853(a)(1)(A) with respect to a  
8 Medicare+Choice plan and the Secretary  
9 shall apply such reduction to reduce the  
10 premium under section 1839 of each en-  
11 rollee in such plan as provided in section  
12 1840(i).

13 “(ii) AMOUNT OF REDUCTION.—The  
14 amount of the reduction under clause (i)  
15 with respect to any enrollee in a  
16 Medicare+Choice plan—

17 “(I) may not exceed 120 percent  
18 of the premium described under sec-  
19 tion 1839(a)(3); and

20 “(II) shall apply uniformly to  
21 each enrollee of the Medicare+Choice  
22 plan to which such reduction ap-  
23 plies.”.

24 (2) CONFORMING AMENDMENTS.—

1 (A) ADJUSTMENT OF PAYMENTS TO  
 2 MEDICARE+CHOICE ORGANIZATIONS.—Section  
 3 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A))  
 4 is amended by inserting “reduced by the  
 5 amount of any reduction elected under section  
 6 1854(f)(1)(F) and” after “for that area,”.

7 (B) ADJUSTMENT AND PAYMENT OF PART  
 8 B PREMIUMS.—

9 (i) ADJUSTMENT OF PREMIUMS.—  
 10 Section 1839(a)(2) (42 U.S.C.  
 11 1395r(a)(2)) is amended by striking  
 12 “shall” and all that follows and inserting  
 13 the following: “shall be the amount deter-  
 14 mined under paragraph (3), adjusted as  
 15 required in accordance with subsections  
 16 (b), (c), and (f), and to reflect 80 percent  
 17 of any reduction elected under section  
 18 1854(f)(1)(F).”.

19 (ii) PAYMENT OF PREMIUMS.—Section  
 20 1840 (42 U.S.C. 1395s) is amended by  
 21 adding at the end the following new sub-  
 22 section:

23 “(i) In the case of an individual enrolled in a  
 24 Medicare+Choice plan, the Secretary shall provide for  
 25 necessary adjustments of the monthly beneficiary pre-

mium to reflect 80 percent of any reduction elected under section 1854(f)(1)(F). This premium adjustment may be provided directly or as an adjustment to any social security, railroad retirement, and civil service retirement benefits, to the extent which the Secretary determines that such an adjustment is appropriate and feasible with the concurrence of the agencies responsible for the administration of such benefits.”.

(C) INFORMATION COMPARING PLAN PREMIUMS UNDER PART C.—Section 1851(d)(4)(B) (42 U.S.C. 1395w–21(d)(4)(B)) is amended—

(i) by striking “PREMIUMS.—The” and inserting “PREMIUMS.—

“(i) IN GENERAL.—The”; and

(ii) by adding at the end the following new clause:

“(ii) REDUCTIONS.—The reduction in premiums, if any.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to years beginning with 2002.

**SEC. 608. DELAY FROM JULY TO NOVEMBER 2000, IN DEADLINE FOR OFFERING AND WITHDRAWING MEDICARE+CHOICE PLANS FOR 2001.**

Notwithstanding any other provision of law, the deadline for a Medicare+Choice organization to withdraw the



1 offering of a Medicare+Choice plan under part C of title  
 2 XVIII of the Social Security Act (or otherwise to submit  
 3 information required for the offering of such a plan) for  
 4 2001 is delayed from July 1, 2000, to November 15, 2000,  
 5 and any such organization that provided notice of with-  
 6 drawal of such a plan during 2000 before the date of en-  
 7 actment of this Act may rescind such withdrawal at any  
 8 time before November 15, 2000.

9 **SEC. 609. REVISION OF PAYMENT RATES FOR ESRD PA-**  
 10 **TIENTS ENROLLED IN MEDICARE+CHOICE**  
 11 **PLANS.**

12 (a) IN GENERAL.—Section 1853(a)(1)(B) (42 U.S.C.  
 13 1395w–23(a)(1)(B)) is amended by adding at the end the  
 14 following: “In establishing such rates the Secretary shall  
 15 provide for appropriate adjustments to increase each rate  
 16 to reflect the demonstration rate (including the risk-ad-  
 17 justment methodology associated with such rate) of the  
 18 social health maintenance organization end-stage renal  
 19 disease demonstrations established by section 2355 of the  
 20 Deficit Reduction Act of 1984 (Public Law 98–369; 98  
 21 Stat. 1103), as amended by section 13567(b) of the Omni-  
 22 bus Budget Reconciliation Act of 1993 (Public Law 103–  
 23 66; 107 Stat. 608), and shall compute such rates by tak-  
 24 ing into account such factors as renal treatment modality,

1 age, and the underlying cause of the end-stage renal dis-  
 2 ease.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
 4 subsection (a) shall apply to payments for months begin-  
 5 ning with January 2002.

6 (c) PUBLICATION.—The Secretary of Health and  
 7 Human Services, not later than 6 months after the date  
 8 of enactment of this Act, shall publish for public comment  
 9 a description of the appropriate adjustments described in  
 10 the last sentence of section 1853(a)(1)(B) of the Social  
 11 Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by  
 12 subsection (a). The Secretary shall publish such adjust-  
 13 ments in final form by not later than July 1, 2001, so  
 14 that the amendment made by subsection (a) is imple-  
 15 mented on a timely basis consistent with subsection (b).

16 **SEC. 610. MODIFICATION OF PAYMENT RULES FOR CER-**  
 17 **TAIN FRAIL ELDERLY MEDICARE BENE-**  
 18 **FICIARIES.**

19 (a) MODIFICATION OF PAYMENT RULES.—Section  
 20 1853 (42 U.S.C. 1395w–23) is amended—

21 (1) in subsection (a)—

22 (A) in paragraph (1)(A), by striking “sub-  
 23 sections (e), (g), and (i)” and inserting “sub-  
 24 sections (e), (g), (i), and (j)”;

1 (B) in paragraph (3)(D), by inserting  
 2 “paragraph (4) and” after “Subject to”; and

3 (C) by adding at the end the following new  
 4 paragraph:

5 “(4) EXEMPTION FROM RISK-ADJUSTMENT SYS-  
 6 TEM FOR FRAIL ELDERLY BENEFICIARIES EN-  
 7 ROLLED IN SPECIALIZED PROGRAMS.—

8 “(A) IN GENERAL.—In applying the risk-  
 9 adjustment factors established under paragraph  
 10 (3) during the period described in subparagraph  
 11 (B), the limitation under paragraph  
 12 (3)(C)(ii)(I) shall apply to a frail elderly  
 13 Medicare+Choice beneficiary (as defined in  
 14 subsection (j)(3)) who is enrolled in a  
 15 Medicare+Choice plan under a specialized pro-  
 16 gram for the frail elderly (as defined in sub-  
 17 section (j)(2)) during the entire period.

18 “(B) PERIOD OF APPLICATION.—The pe-  
 19 riod described in this subparagraph begins with  
 20 January 2001, and ends with the first month  
 21 for which the Secretary certifies to Congress  
 22 that a comprehensive risk adjustment method-  
 23 ology under paragraph (3)(C) that takes into  
 24 account the factors described in subsection  
 25 (j)(1)(B) is being fully implemented.”; and

1           (2) by adding at the end the following new sub-  
2       section:

3       “(j) SPECIAL RULES FOR FRAIL ELDERLY EN-  
4       ROLLED IN SPECIALIZED PROGRAMS FOR THE FRAIL EL-  
5       DERLY.—

6           “(1) DEVELOPMENT AND IMPLEMENTATION OF  
7       NEW PAYMENT SYSTEM.—

8           “(A) IN GENERAL.—The Secretary shall  
9       develop and implement (as soon as possible  
10      after the date of enactment of the Medicare,  
11      Medicaid, and SCHIP Balanced Budget Refine-  
12      ment Act of 2000) a payment methodology for  
13      frail elderly Medicare+Choice beneficiaries en-  
14      rolled in a Medicare+Choice plan under a spe-  
15      cialized program for the frail elderly (as defined  
16      in paragraph (2)(A)).

17          “(B) FACTORS DESCRIBED.—The method-  
18      ology developed and implemented under sub-  
19      paragraph (A) shall take into account the prev-  
20      alence, mix, and severity of chronic conditions  
21      among frail elderly Medicare+Choice bene-  
22      ficiaries and shall include—

23           “(i) medical diagnostic factors from  
24           all provider settings (including hospital  
25           and nursing facility settings);

1 “(ii) functional indicators of health  
2 status; and

3 “(iii) such other factors as may be  
4 necessary to achieve appropriate payments  
5 for plans serving such beneficiaries.

6 “(2) SPECIALIZED PROGRAM FOR THE FRAIL  
7 ELDERLY DEFINED.—

8 “(A) IN GENERAL.—In this part, the term  
9 ‘specialized program for the frail elderly’ means  
10 a program that the Secretary determines—

11 “(i) is offered under this part as a  
12 distinct part of a Medicare+Choice plan;

13 “(ii) primarily enrolls frail elderly  
14 Medicare+Choice beneficiaries; and

15 “(iii) has a clinical delivery system  
16 that is specifically designed to serve the  
17 special needs of such beneficiaries and to  
18 coordinate short-term and long-term care  
19 for such beneficiaries through the use of a  
20 team described in subparagraph (B) and  
21 through the provision of primary care serv-  
22 ices to such beneficiaries by means of such  
23 a team at the nursing facility involved.

24 “(B) SPECIALIZED TEAM DESCRIBED.—A  
25 team described in this subparagraph—

1 “(i) includes—

2 “(I) a physician; and

3 “(II) a nurse practitioner or geri-  
4atric care manager; and

5 “(ii) has as members individuals  
6 who—

7 “(I) have special training in the  
8 care and management of the frail el-  
9derly beneficiaries; and

10 “(II) specialize in the care and  
11 management of such beneficiaries.

12 “(3) FRAIL ELDERLY MEDICARE+CHOICE BEN-  
13EFICIARY DEFINED.—In this part, the term ‘frail el-  
14derly Medicare+Choice beneficiary’ means a  
15 Medicare+Choice eligible individual who—

16 “(A) is residing in a skilled nursing facility  
17 (as defined in section 1819(a)) or a nursing fa-  
18cility (as defined in section 1919(a)) for an in-  
19definite period and without any intention of re-  
20siding outside the facility; and

21 “(B) has a severity of condition that  
22 makes the individual frail (as determined under  
23 guidelines approved by the Secretary).”.

1 (b) EFFECTIVE DATE.—The amendments made by  
 2 this section shall take effect on the date of enactment of  
 3 this Act.

4 **SEC. 611. FULL IMPLEMENTATION OF RISK ADJUSTMENT**  
 5 **FOR CONGESTIVE HEART FAILURE ENROLL-**  
 6 **EES FOR 2001.**

7 (a) IN GENERAL.—Section 1853(a)(3)(C) (42 U.S.C.  
 8 1395w-23(a)(3)(C)) is amended—

9 (1) in clause (ii), by striking “Such risk adjust-  
 10 ment” and inserting “Except as provided in clause  
 11 (iii), such risk adjustment”; and

12 (2) by adding at the end the following new  
 13 clause:

14 “(iii) FULL IMPLEMENTATION OF  
 15 RISK ADJUSTMENT FOR CONGESTIVE  
 16 HEART FAILURE ENROLLEES FOR 2001.—

17 “(I) EXEMPTION FROM PHASE-  
 18 IN.—Subject to subclause (II), the  
 19 Secretary shall fully implement the  
 20 risk adjustment methodology de-  
 21 scribed in clause (i) with respect to  
 22 each individual who has had a quali-  
 23 fying congestive heart failure inpa-  
 24 tient diagnosis (as determined by the  
 25 Secretary under such risk adjustment

1 methodology) during the period begin-  
 2 ning on July 1, 1999, and ending on  
 3 June 30, 2000, and who is enrolled in  
 4 a coordinated care plan that is the  
 5 only coordinated care plan offered on  
 6 January 1, 2001, in the service area  
 7 of the individual.

8 “(II) PERIOD OF APPLICATION.—

9 Subclause (I) shall only apply during  
 10 the 1-year period beginning on Janu-  
 11 ary 1, 2001.”.

12 (b) EXCLUSION FROM DETERMINATION OF THE  
 13 BUDGET NEUTRALITY FACTOR.—Section 1853(c)(5) (42  
 14 U.S.C. 1395w–23(c)(5)) is amended by striking “sub-  
 15 section (i)” and inserting “subsections (a)(3)(C)(iii) and  
 16 (i)”.

17 **SEC. 612. INCLUSION OF COSTS OF DOD MILITARY TREAT-**  
 18 **MENT FACILITY SERVICES TO MEDICARE-ELI-**  
 19 **GIBLE BENEFICIARIES IN CALCULATION OF**  
 20 **MEDICARE+CHOICE PAYMENT RATES.**

21 Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is  
 22 amended—

23 (1) in subparagraph (A), by striking “subpara-  
 24 graph (B)” and inserting “subparagraphs (B) and  
 25 (E)”; and



(2) by adding at the end the following new subparagraph:

“(E) INCLUSION OF COSTS OF CERTAIN  
DOD MILITARY TREATMENT FACILITY SERVICES  
TO MEDICARE-ELIGIBLE BENEFICIARIES.—

“(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2001), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for a Medicare+Choice payment area that is within 1 or more MTF affected areas (as defined in clause (ii)) shall be increased by the sum of the MTF percentages (as described in clause (iii)) for the MTF affected area or areas. The increase under this subparagraph shall not be taken into account in computing the national standardized annual Medicare+Choice capitation rate under paragraph (4)(B).

“(ii) MTF AFFECTED AREA DEFINED.—In this subparagraph, the term ‘MTF affected area’ means, with respect to a military treatment facility (as defined in

1 subsection (a)(6) of section 1896), an area  
2 that includes the following:

3 “(I) The Medicare+Choice pay-  
4 ment area in which a military treat-  
5 ment facility that was part of the  
6 medicare subvention demonstration  
7 project under such section as of July  
8 1, 2000, is located.

9 “(II) Any Medicare+Choice pay-  
10 ment area which is contiguous to the  
11 area described in subclause (I) and lo-  
12 cated not farther than 40 miles from  
13 the facility.

14 “(iii) MTF PERCENTAGE.—For pur-  
15 poses of clause (i), the MTF percentage  
16 for an MTF affected area is equal to the  
17 ratio of—

18 “(I) the aggregate amount of  
19 costs incurred by the Department of  
20 Defense in furnishing items and serv-  
21 ices to individuals entitled to benefits  
22 under this title who received services  
23 from the military treatment facility  
24 described in clause (ii) for that area  
25 in 1996 (as determined pursuant to

1 section 1896(j)(1)(A)), increased by  
 2 the national per capita  
 3 Medicare+Choice growth percentage  
 4 under paragraph (6) for 1997, to  
 5 “(II) the average number of indi-  
 6 viduals residing in such area in 1996  
 7 entitled to benefits under part A and  
 8 enrolled under part B.”.

## 9 **Subtitle B—Other Medicare+Choice** 10 **Reforms**

### 11 **SEC. 621. AMOUNTS IN MEDICARE TRUST FUNDS AVAIL-** 12 **ABLE FOR SECRETARY'S SHARE OF** 13 **MEDICARE+CHOICE EDUCATION AND EN-** 14 **ROLLMENT-RELATED COSTS.**

15 (a) RELOCATION OF PROVISIONS.—Section  
 16 1857(e)(2) (42 U.S.C. 1395w–27(e)(2)) is amended to  
 17 read as follows:

18 “(2) COST-SHARING IN ENROLLMENT-RELATED  
 19 COSTS.—A Medicare+Choice organization shall pay  
 20 the fee established by the Secretary under section  
 21 1851(j)(3)(A).”.

22 (b) FUNDING FOR EDUCATION AND ENROLLMENT  
 23 ACTIVITIES.—Section 1851 (42 U.S.C. 1395w–21) is  
 24 amended by adding at the end the following new sub-  
 25 section:

1       “(j) FUNDING FOR BENEFICIARY EDUCATION AND  
2 ENROLLMENT ACTIVITIES.—

3               “(1) SECRETARY’S ESTIMATE OF TOTAL  
4 COSTS.—The Secretary shall annually estimate the  
5 total cost for a fiscal year of carrying out this sec-  
6 tion, section 4360 of the Omnibus Budget Reconcili-  
7 ation Act of 1990 (relating to the health insurance  
8 counseling and assistance program), and related ac-  
9 tivities.

10              “(2) TOTAL AMOUNT AVAILABLE.—The total  
11 amount available to the Secretary for a fiscal year  
12 for the costs of the activities described in paragraph  
13 (1) shall be equal to the lesser of—

14                      “(A) the amount estimated for such fiscal  
15 year under paragraph (1); or

16                      “(B) for—

17                              “(i) fiscal year 2001, \$115,000,000;  
18 and

19                              “(ii) fiscal year 2002 and each subse-  
20 quent fiscal year, the amount for the pre-  
21 vious fiscal year, adjusted to account for  
22 inflation, any change in the number of  
23 beneficiaries under this title, and any other  
24 relevant factors.

1           “(3) COST-SHARING IN ENROLLMENT-RELATED  
2 COSTS.—

3           “(A) AMOUNTS FROM MEDICARE+CHOICE  
4 ORGANIZATIONS.—

5           “(i) IN GENERAL.—The Secretary is  
6 authorized to charge a fee to each  
7 Medicare+Choice organization with a con-  
8 tract under this part that is equal to the  
9 organization’s pro rata share (as deter-  
10 mined by the Secretary) of the  
11 Medicare+Choice portion (as defined in  
12 clause (ii)) of the total amount available  
13 under paragraph (2) for a fiscal year. Any  
14 amounts collected shall be available with-  
15 out further appropriation to the Secretary  
16 for the costs of the activities described in  
17 paragraph (1).

18           “(ii) MEDICARE+CHOICE PORTION  
19 DEFINED.—For purposes of clause (i), the  
20 term ‘Medicare+Choice portion’ means, for  
21 a fiscal year, the ratio, as estimated by the  
22 Secretary, of—

23           “(I) the average number of indi-  
24 viduals enrolled in Medicare+Choice  
25 plans during the fiscal year; to

1                   “(II) the average number of indi-  
2                   viduals entitled to benefits under part  
3                   A, and enrolled under part B, during  
4                   the fiscal year.

5                   “(B) SECRETARY’S SHARE.—

6                   “(i) AMOUNTS AVAILABLE FROM  
7                   TRUST FUNDS.—The Secretary’s share of  
8                   expenses shall be payable from funds in  
9                   the Federal Hospital Insurance Trust  
10                  Fund and the Federal Supplementary  
11                  Medical Insurance Trust Fund, in such  
12                  proportion as the Secretary shall deem to  
13                  be fair and equitable after taking into con-  
14                  sideration the expenses attributable to the  
15                  administration of this part with respect to  
16                  parts A and B. The Secretary shall make  
17                  such transfers of moneys between such  
18                  Trust Funds as may be appropriate to set-  
19                  tle accounts between the Trust Funds in  
20                  cases where expenses properly payable  
21                  from one such Trust Fund have been paid  
22                  from the other such Trust Fund.

23                  “(ii) SECRETARY’S SHARE OF EX-  
24                  PENSES DEFINED.—For purposes of clause  
25                  (i), the term ‘Secretary’s share of ex-

penses' means, for a fiscal year, an amount equal to—

“(I) the total amount available to the Secretary under paragraph (2) for the fiscal year; less

“(II) the amount collected under subparagraph (A) for the fiscal year.”.

**SEC. 622. SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMINATION PROVISION FOR CERTAIN BENEFICIARIES.**

(a) DISENROLLMENT WINDOW IN ACCORDANCE WITH BENEFICIARY'S CIRCUMSTANCE.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(1) in subparagraph (A), in the matter following clause (iii), by striking “, subject to subparagraph (E), seeks to enroll under the policy not later than 63 days after the date of termination of enrollment described in such subparagraph” and inserting “seeks to enroll under the policy during the period specified in subparagraph (E)”; and

(2) by striking subparagraph (E) and inserting the following new subparagraph:

“(E) For purposes of subparagraph (A), the time period specified in this subparagraph is—

1           “(i) in the case of an individual described in  
2           subparagraph (B)(i), the period beginning on the  
3           date the individual receives a notice of termination  
4           or cessation of all supplemental health benefits (or,  
5           if no such notice is received, notice that a claim has  
6           been denied because of such a termination or ces-  
7           sation) and ending on the date that is 63 days after  
8           the applicable notice;

9           “(ii) in the case of an individual described in  
10          clause (ii), (iii), (v), or (vi) of subparagraph (B)  
11          whose enrollment is terminated involuntarily, the pe-  
12          riod beginning on the date that the individual re-  
13          ceives a notice of termination and ending on the  
14          date that is 63 days after the date the applicable  
15          coverage is terminated;

16          “(iii) in the case of an individual described in  
17          subparagraph (B)(iv)(I), the period beginning on the  
18          earlier of (I) the date that the individual receives a  
19          notice of termination, a notice of the issuer’s bank-  
20          ruptcy or insolvency, or other such similar notice, if  
21          any, and (II) the date that the applicable coverage  
22          is terminated, and ending on the date that is 63  
23          days after the date the coverage is terminated;

24          “(iv) in the case of an individual described in  
25          clause (ii), (iii), (iv)(II), (iv)(III), (v), or (vi) of sub-



1 paragraph (B) who disenrolls voluntarily, the period  
 2 beginning on the date that is 60 days before the ef-  
 3 fective date of the disenrollment and ending on the  
 4 date that is 63 days after such effective date; and

5 “(v) in the case of an individual described in  
 6 subparagraph (B) but not described in the preceding  
 7 provisions of this subparagraph, the period begin-  
 8 ning on the effective date of the disenrollment and  
 9 ending on the date that is 63 days after such effec-  
 10 tive date.”.

11 (b) EXTENDED MEDIGAP ACCESS FOR INTERRUPTED  
 12 TRIAL PERIODS.—Section 1882(s)(3) (42 U.S.C.  
 13 1395ss(s)(3)), as amended by subsection (a), is amended  
 14 by adding at the end the following new subparagraph:

15 “(F)(i) Subject to clause (ii), for purposes of this  
 16 paragraph—

17 “(I) in the case of an individual described in  
 18 subparagraph (B)(v) (or deemed to be so described,  
 19 pursuant to this subparagraph) whose enrollment  
 20 with an organization or provider described in sub-  
 21 clause (II) of such subparagraph is involuntarily ter-  
 22 minated within the first 12 months of such enroll-  
 23 ment, and who, without an intervening enrollment,  
 24 enrolls with another such organization or provider,  
 25 such subsequent enrollment shall be deemed to be an

1 initial enrollment described in such subparagraph;  
 2 and

3 “(II) in the case of an individual described in  
 4 clause (vi) of subparagraph (B) (or deemed to be so  
 5 described, pursuant to this subparagraph) whose en-  
 6 rollment with a plan or in a program described in  
 7 such clause is involuntarily terminated within the  
 8 first 12 months of such enrollment, and who, with-  
 9 out an intervening enrollment, enrolls in another  
 10 such plan or program, such subsequent enrollment  
 11 shall be deemed to be an initial enrollment described  
 12 in such clause.

13 “(ii) For purposes of clauses (v) and (vi) of subpara-  
 14 graph (B), no enrollment of an individual with an organi-  
 15 zation or provider described in clause (v)(II), or with a  
 16 plan or in a program described in clause (vi), may be  
 17 deemed to be an initial enrollment under this clause after  
 18 the 2-year period beginning on the date on which the indi-  
 19 vidual first enrolled with such an organization, provider,  
 20 plan, or program.”.

21 **SEC. 623. RESTORING EFFECTIVE DATE OF ELECTIONS AND**  
 22 **CHANGES OF ELECTIONS OF**  
 23 **MEDICARE+CHOICE PLANS.**

24 (a) OPEN ENROLLMENT.—Section 1851(f)(2) (42  
 25 U.S.C. 1395w–21(f)(2)) is amended by striking “, except

1 that if such election or change is made after the 10th day  
 2 of any calendar month, then the election or change shall  
 3 not take effect until the first day of the second calendar  
 4 month following the date on which the election or change  
 5 is made”.

6 (b) EFFECTIVE DATE.—The amendment made by  
 7 this section shall apply to elections and changes of cov-  
 8 erage made on or after January 1, 2001.

9 **SEC. 624. PERMITTING ESRD BENEFICIARIES TO ENROLL**  
 10 **IN ANOTHER MEDICARE+CHOICE PLAN IF**  
 11 **THE PLAN IN WHICH THEY ARE ENROLLED IS**  
 12 **TERMINATED.**

13 (a) IN GENERAL.—Section 1851(a)(3)(B) (42 U.S.C.  
 14 1395w–21(a)(3)(B)) is amended by striking “except that”  
 15 and all that follows and inserting the following: “except  
 16 that—

17 “(i) an individual who develops end-  
 18 stage renal disease while enrolled in a  
 19 Medicare+Choice plan may continue to be  
 20 enrolled in that plan; and

21 “(ii) in the case of such an individual  
 22 who is enrolled in a Medicare+Choice plan  
 23 under clause (i) (or subsequently under  
 24 this clause), if the enrollment is discon-  
 25 tinued under circumstances described in

1           section 1851(e)(4)(A), then the individual  
2           will be treated as a ‘Medicare+Choice eli-  
3           gible individual’ for purposes of electing to  
4           continue enrollment in another  
5           Medicare+Choice plan.”.

6       (b) EFFECTIVE DATE.—

7           (1) IN GENERAL.—The amendment made by  
8           subsection (a) shall apply to terminations and  
9           discontinuations occurring on or after the date of  
10          enactment of this Act.

11          (2) APPLICATION TO PRIOR PLAN TERMI-  
12          NATIONS.—Clause (ii) of section 1851(a)(3)(B) of  
13          the Social Security Act (as inserted by subsection  
14          (a)) also shall apply to individuals whose enrollment  
15          in a Medicare+Choice plan was terminated or dis-  
16          continued after December 31, 1997, and before the  
17          date of enactment of this Act. In applying this para-  
18          graph, such an individual shall be treated, for pur-  
19          poses of part C of title XVIII of the Social Security  
20          Act, as having discontinued enrollment in such a  
21          plan as of the date of enactment of this Act.

1 **SEC. 625. ELECTION OF UNIFORM LOCAL COVERAGE POL-**  
2 **ICY FOR MEDICARE+CHOICE PLAN COVERING**  
3 **MULTIPLE LOCALITIES.**

4 Section 1852(a)(2) (42 U.S.C. 1395w-22(a)(2)) is  
5 amended by adding at the end the following new subpara-  
6 graph:

7 “(C) ELECTION OF UNIFORM COVERAGE  
8 POLICY.—With respect to each item or service  
9 furnished by a Medicare+Choice organization  
10 that offers a Medicare+Choice plan in a geo-  
11 graphic area that includes at least 15 States  
12 and in which more than 1 local coverage policy  
13 is applied with respect to different parts of the  
14 area, the organization may elect to have the  
15 local coverage policy for the part of the area  
16 that affords the broadest coverage to  
17 Medicare+Choice enrollees (as determined by  
18 the Secretary) with respect to such item or  
19 service apply with respect to all  
20 Medicare+Choice enrollees enrolled in the  
21 plan.”.

1     **Subtitle C—Other Managed Care**  
 2                     **Reforms**

3     **SEC. 631. REVISED TERMS AND CONDITIONS FOR EXTEN-**  
 4                     **SION OF MEDICARE COMMUNITY NURSING**  
 5                     **ORGANIZATION (CNO) DEMONSTRATION**  
 6                     **PROJECT.**

7             (a) IN GENERAL.—Section 532 of BBRA (42 U.S.C.  
 8     1395mm note) is amended—

9                     (1) in subsection (a), by striking the second  
 10             sentence; and

11                    (2) by striking subsection (b) and inserting the  
 12             following new subsections:

13             “(b) TERMS AND CONDITIONS.—

14                    “(1) JANUARY THROUGH SEPTEMBER 2000.—  
 15             For the 9-month period beginning with January  
 16             2000, any such demonstration project shall be con-  
 17             ducted under the same terms and conditions as ap-  
 18             plied to such project during 1999.

19                    “(2) OCTOBER 2000 THROUGH DECEMBER  
 20             2001.—For the 15-month period beginning with Oc-  
 21             tober 2000, any such demonstration project shall be  
 22             conducted under the same terms and conditions as  
 23             applied to such project during 1999, except that the  
 24             following modifications shall apply:

“(A) BASIC CAPITATION RATE.—The basic capitation rate paid for services covered under the project (other than case management services) per enrollee per month shall be the basic capitation rate paid for such services for 1999, reduced by 10 percent in the case of the demonstration sites located in Arizona, Minnesota, and Illinois, and 15 percent for the demonstration site located in New York.

“(B) TARGETED CASE MANAGEMENT FEE.—A case management fee shall be paid only for enrollees who are classified as ‘moderate’ or ‘at risk’ through a baseline health assessment (as required for Medicare+Choice plans under section 1852(e) of the Social Security Act (42 U.S.C. 1395ww-22(e)).

“(C) GREATER UNIFORMITY IN CLINICAL FEATURES AMONG SITES.—The project shall implement for each site—

“(i) protocols for periodic telephonic contact with enrollees based on—

“(I) the results of such standardized written health assessment; and

“(II) the application of appropriate care planning approaches;

1           “(ii) disease management programs  
 2           for targeted diseases (such as congestive  
 3           heart failure, arthritis, diabetes, and hy-  
 4           pertension) that are highly prevalent in the  
 5           enrolled populations;

6           “(iii) systems and protocols to track  
 7           enrollees through hospitalizations, includ-  
 8           ing preadmission planning, concurrent  
 9           management during inpatient hospital  
 10          stays, and post-discharge assessment, plan-  
 11          ning, and followup; and

12          “(iv) standardized patient educational  
 13          materials for specified diseases and health  
 14          conditions.

15          “(D)     QUALITY     IMPROVEMENT.—The  
 16          project shall implement at each site once during  
 17          the 15-month period—

18                 “(i) surveys on enrollee satisfaction;  
 19                 and

20                 “(ii) reports on specified quality indi-  
 21                 cators for the enrolled population.

22          “(c) EVALUATION.—

23                 “(1) PRELIMINARY REPORT.—Not later than  
 24          July 1, 2001, the Secretary of Health and Human  
 25          Services shall submit to the Committees on Ways



1 and Means and Commerce of the House of Rep-  
2 resentatives and the Committee on Finance of the  
3 Senate a preliminary report that—

4 “(A) evaluates such demonstration projects  
5 for the period beginning July 1, 1997, and end-  
6 ing December 31, 1999, on a site-specific basis  
7 with respect to the impact on per beneficiary  
8 spending, specific health utilization measures,  
9 and enrollee satisfaction; and

10 “(B) includes a similar evaluation of such  
11 projects for the portion of the extension period  
12 that occurs after September 30, 2000.

13 “(2) FINAL REPORT.—The Secretary shall sub-  
14 mit a final report to such Committees on such dem-  
15 onstration projects not later than July 1, 2002.  
16 Such report shall include the same elements as the  
17 preliminary report required by paragraph (1), but  
18 for the period after December 31, 1999.

19 “(3) METHODOLOGY FOR SPENDING COMPARI-  
20 SONS.—Any evaluation of the impact of the dem-  
21 onstration projects on per beneficiary spending in-  
22 cluded in such reports shall be based on a compari-  
23 son of—

24 “(A) data for all individuals who—

1 “(i) were enrolled in such demonstra-  
 2 tion projects as of the first day of the pe-  
 3 riod under evaluation; and

4 “(ii) were enrolled for a minimum of  
 5 6 months thereafter; with

6 “(B) data for a matched sample of individ-  
 7 uals who are enrolled under part B of title  
 8 XVIII of the Social Security Act (42 U.S.C.  
 9 1395j et seq.) and who are not enrolled in such  
 10 a project, in a Medicare+Choice plan under  
 11 part C of such title (42 U.S.C. 1395w-21 et  
 12 seq.), a plan offered by an eligible organization  
 13 under section 1876 of such Act (42 U.S.C.  
 14 1395mm), or a health care prepayment plan  
 15 under section 1833(a)(1)(A) of such Act (42  
 16 U.S.C. 1395l(a)(1)(A)).”.

17 (b) EFFECTIVE DATE.—The amendments made by  
 18 subsection (a) shall be effective as if included in the enact-  
 19 ment of section 532 of BBRA (42 U.S.C. 1395mm note).

20 **SEC. 632. SERVICE AREA EXPANSION FOR MEDICARE COST**  
 21 **CONTRACTS DURING TRANSITION PERIOD.**

22 Section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is  
 23 amended—

24 (1) by redesignating subparagraph (B) as sub-  
 25 paragraph (C); and

1           (2) by inserting after subparagraph (A), the fol-  
 2       lowing new subparagraph:

3       “(B) Subject to subparagraph (C), the Secretary  
 4 shall approve an application for a modification to a rea-  
 5 sonable cost contract under this section in order to expand  
 6 the service area of such contract if—

7           “(i) such application is submitted to the Sec-  
 8       retary on or before September 1, 2003; and

9           “(ii) the Secretary determines that the organi-  
 10       zation with the contract continues to meet the re-  
 11       quirements applicable to such organizations and con-  
 12       tracts under this section.”.

## 13                   **TITLE VII—MEDICAID**

### 14   **SEC. 701. NEW PROSPECTIVE PAYMENT SYSTEM FOR FED-** 15                   **ERALLY-QUALIFIED HEALTH CENTERS AND** 16                   **RURAL HEALTH CLINICS.**

17       (a) IN GENERAL.—Section 1902(a) (42 U.S.C.  
 18 1396a(a)) is amended—

19           (1) in paragraph (13)—

20                   (A) in subparagraph (A), by adding “and”  
 21       at the end;

22                   (B) in subparagraph (B), by striking  
 23       “and” at the end; and

24                   (C) by striking subparagraph (C); and

1           (2) by inserting after paragraph (14) the fol-  
 2           lowing new paragraph:

3           “(15) provide for payment for services de-  
 4           scribed in subparagraph (B) or (C) of section  
 5           1905(a)(2) under the plan in accordance with sub-  
 6           section (aa);”.

7           (b) NEW PROSPECTIVE PAYMENT SYSTEM.—Section  
 8           1902 (42 U.S.C. 1396a) is amended by adding at the end  
 9           the following:

10          “(aa) PAYMENT FOR SERVICES PROVIDED BY FED-  
 11          ERALLY-QUALIFIED HEALTH CENTERS AND RURAL  
 12          HEALTH CLINICS.—

13               “(1) IN GENERAL.—Beginning with fiscal year  
 14               2001 and each succeeding fiscal year, the State plan  
 15               shall provide for payment for services described in  
 16               section 1905(a)(2)(C) furnished by a Federally-  
 17               qualified health center and services described in sec-  
 18               tion 1905(a)(2)(B) furnished by a rural health clinic  
 19               in accordance with the provisions of this subsection.

20               “(2) FISCAL YEAR 2001.—Subject to paragraph  
 21               (4), for services furnished during fiscal year 2001,  
 22               the State plan shall provide for payment for such  
 23               services in an amount (calculated on a per visit  
 24               basis) that is equal to 100 percent of the average of  
 25               the costs of the center or clinic of furnishing such

1 services during fiscal years 1999 and 2000 which  
2 are reasonable and related to the cost of furnishing  
3 such services, or based on such other tests of reason-  
4 ableness as the Secretary prescribes in regulations  
5 under section 1833(a)(3), or, in the case of services  
6 to which such regulations do not apply, the same  
7 methodology used under section 1833(a)(3), ad-  
8 justed to take into account any increase or decrease  
9 in the scope of such services furnished by the center  
10 or clinic during fiscal year 2001.

11 “(3) FISCAL YEAR 2002 AND SUCCEEDING FIS-  
12 CAL YEARS.—Subject to paragraph (4), for services  
13 furnished during fiscal year 2002 or a succeeding  
14 fiscal year, the State plan shall provide for payment  
15 for such services in an amount (calculated on a per  
16 visit basis) that is equal to the amount calculated for  
17 such services under this subsection for the preceding  
18 fiscal year—

19 “(A) increased by the percentage increase  
20 in the MEI (as defined in section 1842(i)(3))  
21 applicable to primary care services (as defined  
22 in section 1842(i)(4)) for that fiscal year; and

23 “(B) adjusted to take into account any in-  
24 crease or decrease in the scope of such services

1           furnished by the center or clinic during that fis-  
2           cal year.

3           “(4) ESTABLISHMENT OF INITIAL YEAR PAY-  
4           MENT AMOUNT FOR NEW CENTERS OR CLINICS.—In  
5           any case in which an entity first qualifies as a Fed-  
6           erally-qualified health center or rural health clinic  
7           after fiscal year 2000, the State plan shall provide  
8           for payment for services described in section  
9           1905(a)(2)(C) furnished by the center or services  
10          described in section 1905(a)(2)(B) furnished by the  
11          clinic in the first fiscal year in which the center or  
12          clinic so qualifies in an amount (calculated on a per  
13          visit basis) that is equal to 100 percent of the costs  
14          of furnishing such services during such fiscal year  
15          based on the rates established under this subsection  
16          for the fiscal year for other such centers or clinics  
17          located in the same or adjacent area with a similar  
18          case load or, in the absence of such a center or clin-  
19          ic, in accordance with the regulations and method-  
20          ology referred to in paragraph (2) or based on such  
21          other tests of reasonableness as the Secretary may  
22          specify. For each fiscal year following the fiscal year  
23          in which the entity first qualifies as a Federally-  
24          qualified health center or rural health clinic, the

1 State plan shall provide for the payment amount to  
2 be calculated in accordance with paragraph (3).

3 “(5) ADMINISTRATION IN THE CASE OF MAN-  
4 AGED CARE.—

5 “(A) IN GENERAL.—In the case of services  
6 furnished by a Federally-qualified health center  
7 or rural health clinic pursuant to a contract be-  
8 tween the center or clinic and a managed care  
9 entity (as defined in section 1932(a)(1)(B)), the  
10 State plan shall provide for payment to the cen-  
11 ter or clinic by the State of a supplemental pay-  
12 ment equal to the amount (if any) by which the  
13 amount determined under paragraphs (2), (3),  
14 and (4) of this subsection exceeds the amount  
15 of the payments provided under the contract.

16 “(B) PAYMENT SCHEDULE.—The supple-  
17 mental payment required under subparagraph  
18 (A) shall be made pursuant to a payment  
19 schedule agreed to by the State and the Feder-  
20 ally-qualified health center or rural health clin-  
21 ic.

22 “(6) ALTERNATIVE PAYMENT METHODOLO-  
23 GIES.—Notwithstanding any other provision of this  
24 section, the State plan may provide for payment in  
25 any fiscal year to a Federally-qualified health center

1 for services described in section 1905(a)(2)(C) or to  
 2 a rural health clinic for services described in section  
 3 1905(a)(2)(B) in an amount which is determined  
 4 under an alternative payment methodology that—

5 “(A) is agreed to by the State and the cen-  
 6 ter or clinic; and

7 “(B) results in payment to the center or  
 8 clinic of an amount which is at least equal to  
 9 the amount otherwise required to be paid to the  
 10 center or clinic under this section.”.

11 (c) CONFORMING AMENDMENTS.—

12 (1) Section 4712 of the BBA (Public Law 105–  
 13 33; 111 Stat. 508) is amended by striking sub-  
 14 section (c).

15 (2) Section 1915(b) (42 U.S.C. 1396n(b)) is  
 16 amended by striking “1902(a)(13)(E)” and insert-  
 17 ing “1902(a)(15), 1902(aa),”.

18 (d) GAO STUDY OF FUTURE REBASING.—The  
 19 Comptroller General of the United States shall provide for  
 20 a study on the need for, and how to, rebase or refine costs  
 21 for making payment under the medicaid program for serv-  
 22 ices provided by Federally-qualified health centers and  
 23 rural health centers (as provided under the amendments  
 24 made by this section). The Comptroller General shall pro-  
 25 vide for submittal of a report on such study to Congress



1 by not later than 4 years after the date of the enactment  
2 of this Act.

3 (e) EFFECTIVE DATE.—The amendments made by  
4 this section take effect on October 1, 2000, and apply to  
5 services furnished on or after such date.

6 **SEC. 702. MEDICAID DSH ALLOTMENTS.**

7 (a) ONE-YEAR FREEZE IN MEDICAID DSH ALLOT-  
8 MENTS.—Section 1923(f)(2) (42 U.S.C. 1396r–4(f)(2)) is  
9 amended—

10 (1) in the matter preceding the table, by insert-  
11 ing “(and the DSH allotment for a State for fiscal  
12 year 2001 is the same as the DSH allotment for the  
13 State for fiscal year 2000, as determined under the  
14 following table)” after “2002”; and

15 (2) in the table—

16 (A) by striking the column in the table re-  
17 lating to FY 01 (fiscal year 2001); and

18 (B) by striking the heading in such table  
19 relating to FY 00 (fiscal year 2000) and insert-  
20 ing “FYS 00, 01”.

21 (b) EFFECTIVE DATE.—The amendments made by  
22 this section take effect on October 1, 2000.

1 **SEC. 703. PERMANENT EXTENSION OF PAYMENT OF MEDI-**  
2 **CARE PART B PREMIUMS FOR QUALIFIED**  
3 **MEDICARE BENEFICIARIES WITH INCOME UP**  
4 **TO 135 PERCENT OF POVERTY.**

5 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42  
6 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

7 (1) in the matter preceding subclause (I), by  
8 striking “(but only for premiums payable with re-  
9 spect to months during the period beginning with  
10 January 1998, and ending with December 2002)”;

11 (2) in subclause (I), by inserting “only for pre-  
12 miums payable with respect to months beginning  
13 with January 1998,” after “(I)”; and

14 (3) in subclause (II), by inserting “only for pre-  
15 miums payable with respect to months during the  
16 period beginning with January 1998, and ending  
17 with December 2002,” after “(II)”.

18 (b) CONFORMING AMENDMENT.—Section 1933(c)(1)  
19 (42 U.S.C. 1396u–3(c)(1)) is amended—

20 (1) in subparagraph (D), by striking “and” at  
21 the end;

22 (2) in subparagraph (E), by striking the period  
23 and inserting “; and”; and

24 (3) by adding at the end the following new sub-  
25 paragraph:

1           “(F) fiscal year 2003 and each fiscal year  
 2           thereafter, the amount specified under this  
 3           paragraph for the preceding fiscal year in-  
 4           creased by the percentage increase (if any) in  
 5           the medical care expenditure category of the  
 6           Consumer Price Index for All Urban Con-  
 7           sumers (United States city average).”.

8   **SEC. 704. STREAMLINED APPROVAL OF CONTINUED STATE-**  
 9                           **WIDE SECTION 1115 MEDICAID WAIVERS.**

10       (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)  
 11 is amended by adding at the end the following new sub-  
 12 section:

13       “(f) An application by the chief executive officer of  
 14 a State for an extension of a waiver project the State is  
 15 operating under an extension under subsection (e) (in this  
 16 subsection referred to as the ‘waiver project’) shall be sub-  
 17 mitted and approved or disapproved in accordance with  
 18 the following:

19           “(1) The application for an extension of the  
 20 waiver project shall be submitted to the Secretary at  
 21 least 120 days prior to the expiration of the current  
 22 period of the waiver project.

23           “(2) Not later than 45 days after the date such  
 24 application is received by the Secretary, the Sec-  
 25 retary shall notify the State if the Secretary intends

1 to review the existing terms and conditions of the  
2 waiver project. A failure to provide such notification  
3 shall be deemed to be an approval of the application.

4 “(3) Not later than 45 days after the date of  
5 a notification made in accordance with paragraph  
6 (2), the Secretary shall inform the State of proposed  
7 changes in the terms and conditions of the waiver  
8 project. A failure to provide such information shall  
9 be deemed to be an approval of the application.

10 “(4) During the 30-day period that begins on  
11 the date information described in paragraph (3) is  
12 provided to a State, the Secretary shall negotiate re-  
13 vised terms and conditions of the waiver project with  
14 the State.

15 “(5)(A) Not later than 120 days after the date  
16 an application for an extension of the waiver project  
17 is submitted to the Secretary (or such later date  
18 agreed to by the chief executive officer of the State),  
19 the Secretary shall—

20 “(i) approve the application subject to such  
21 modifications in the terms and conditions—

22 “(I) as have been agreed to by the  
23 Secretary and the State; or

24 “(II) in the absence of such agree-  
25 ment, as are determined by the Secretary

1 to be reasonable consistent with the overall  
 2 objectives of the waiver project; or

3 “(ii) disapprove the application.

4 “(B) A failure by the Secretary to approve or  
 5 disapprove an application submitted under this sub-  
 6 section in accordance with the requirements of sub-  
 7 paragraph (A) shall be deemed to be an approval of  
 8 the application subject to such modifications in the  
 9 terms and conditions as have been agreed to (if any)  
 10 by the Secretary and the State.

11 “(6) An approval of an application for an exten-  
 12 sion of a waiver project under this subsection shall  
 13 be for a period requested by the State, not to exceed  
 14 3 years.

15 “(7) An extension of a waiver project under this  
 16 subsection shall be subject to the final reporting and  
 17 evaluation requirements of paragraphs (4) and (5)  
 18 of subsection (e).”.

19 (b) EFFECTIVE DATE.—The amendment made by  
 20 subsection (a) applies to requests for extensions of dem-  
 21 onstration projects pending or submitted on or after the  
 22 date of enactment of this Act.

23 **SEC. 705. ALASKA FMAP.**

24 (a) IN GENERAL.—The first sentence of section  
 25 1905(b) (42 U.S.C. 1396d(b)) is amended—

1 (1) by striking “and (3)” and inserting “(3)”;  
 2 and

3 (2) by striking the period and inserting “, and  
 4 (4) only with respect to each of fiscal years 2001  
 5 through 2005, for purposes of this title and title  
 6 XXI, the State percentage used to determine the  
 7 Federal medical assistance percentage for Alaska  
 8 shall be that percentage which bears the same ratio  
 9 to 45 percent as the square of the adjusted per cap-  
 10 ita income of Alaska (determined by dividing the  
 11 State’s 3-year average per capita income by 1.05)  
 12 bears to the square of the per capita income of the  
 13 50 States.”.

14 (b) EFFECTIVE DATE.—The amendments made by  
 15 subsection (a) take effect October 1, 2000.

16 **TITLE VIII—STATE CHILDREN’S**  
 17 **HEALTH INSURANCE PRO-**  
 18 **GRAM (SCHIP)**

19 **SEC. 801. SPECIAL RULE FOR REDISTRIBUTION AND AVAIL-**  
 20 **ABILITY OF UNUSED FISCAL YEAR 1998 AND**  
 21 **1999 SCHIP ALLOTMENTS.**

22 (a) CHANGE IN RULES FOR REDISTRIBUTION AND  
 23 RETENTION OF UNUSED SCHIP ALLOTMENTS FOR FIS-  
 24 CAL YEARS 1998 AND 1999.—Section 2104 (42 U.S.C.

1 1397dd) is amended by adding at the end the following  
 2 new subsection:

3 “(g) RULE FOR REDISTRIBUTION AND EXTENDED  
 4 AVAILABILITY OF FISCAL YEARS 1998 AND 1999 ALLOT-  
 5 MENTS.—

6 “(1) AMOUNT REDISTRIBUTED.—

7 “(A) IN GENERAL.—In the case of a State  
 8 that expends all of its allotment under sub-  
 9 section (b) or (c) for fiscal year 1998 by the  
 10 end of fiscal year 2000, or for fiscal year 1999  
 11 by the end of fiscal year 2001, the Secretary  
 12 shall redistribute to the State under subsection  
 13 (f) (from the fiscal year 1998 or 1999 allot-  
 14 ments of other States, respectively, as deter-  
 15 mined by the application of paragraphs (2) and  
 16 (3) with respect to the respective fiscal year))  
 17 the following amount:

18 “(i) STATE.—In the case of 1 of the  
 19 50 States or the District of Columbia, with  
 20 respect to—

21 “(I) the fiscal year 1998 allot-  
 22 ment, the amount by which the  
 23 State’s expenditures under this title in  
 24 fiscal years 1998, 1999, and 2000 ex-

1           ceed the State's allotment for fiscal  
2           year 1998 under subsection (b); or

3           “(II) the fiscal year 1999 allot-  
4           ment, the amount by which the  
5           State's expenditures under this title in  
6           fiscal years 1999, 2000, and 2001 ex-  
7           ceed the State's allotment for fiscal  
8           year 1999 under subsection (b).

9           “(ii) TERRITORY.—In the case of a  
10          commonwealth or territory described in  
11          subsection (c)(3), an amount that bears  
12          the same ratio to 1.05 percent of the total  
13          amount described in paragraph (2)(B)(i)(I)  
14          as the ratio of the commonwealth's or ter-  
15          ritory's fiscal year 1998 or 1999 allotment  
16          under subsection (c) (as the case may be)  
17          bears to the total of all such allotments for  
18          such fiscal year under such subsection.

19          “(B) EXPENDITURE RULES.—An amount  
20          redistributed to a State under this paragraph  
21          with respect to fiscal year 1998 or 1999—

22               “(i) shall not be included in the deter-  
23               mination of the State's allotment for any  
24               fiscal year under this section;



1           “(ii) notwithstanding subsection (e),  
 2           shall remain available for expenditure by  
 3           the State through the end of fiscal year  
 4           2002; and

5           “(iii) shall be counted as being ex-  
 6           pended with respect to a fiscal year allot-  
 7           ment in accordance with applicable regula-  
 8           tions of the Secretary.

9           “(2) EXTENSION OF AVAILABILITY OF PORTION  
 10          OF UNEXPENDED FISCAL YEARS 1998 AND 1999 AL-  
 11          LOTMENTS.—

12           “(A) IN GENERAL.—Notwithstanding sub-  
 13          section (e):

14           “(i) FISCAL YEAR 1998 ALLOTMENT.—

15           Of the amounts allotted to a State pursu-  
 16           ant to this section for fiscal year 1998 that  
 17           were not expended by the State by the end  
 18           of fiscal year 2000, the amount specified in  
 19           subparagraph (B) for fiscal year 1998 for  
 20           such State shall remain available for ex-  
 21           penditure by the State through the end of  
 22           fiscal year 2002.

23           “(ii) FISCAL YEAR 1999 ALLOT-  
 24           MENT.—Of the amounts allotted to a State  
 25           pursuant to this subsection for fiscal year

1           1999 that were not expended by the State  
 2           by the end of fiscal year 2001, the amount  
 3           specified in subparagraph (B) for fiscal  
 4           year 1999 for such State shall remain  
 5           available for expenditure by the State  
 6           through the end of fiscal year 2002.

7           “(B) AMOUNT REMAINING AVAILABLE FOR  
 8           EXPENDITURE.—The amount specified in this  
 9           subparagraph for a State for a fiscal year is  
 10          equal to—

11           “(i) the amount by which (I) the total  
 12           amount available for redistribution under  
 13           subsection (f) from the allotments for that  
 14           fiscal year, exceeds (II) the total amounts  
 15           redistributed under paragraph (1) for that  
 16           fiscal year; multiplied by

17           “(ii) the ratio of the amount of such  
 18           State’s unexpended allotment for that fis-  
 19           cal year to the total amount described in  
 20           clause (i)(I) for that fiscal year.

21           “(C) USE OF UP TO 10 PERCENT OF RE-  
 22           TAINED 1998 ALLOTMENTS FOR OUTREACH AC-  
 23           TIVITIES.—Notwithstanding                    section  
 24           2105(c)(2)(A), with respect to any State de-  
 25           scribed in subparagraph (A)(i), the State may

1           use up to 10 percent of the amount specified  
2           in subparagraph (B) for fiscal year 1998 for ex-  
3           penditures for outreach activities approved by  
4           the Secretary.

5           “(3) DETERMINATION OF AMOUNTS.—For pur-  
6           poses of calculating the amounts described in para-  
7           graphs (1) and (2) relating to the allotment for fis-  
8           cal year 1998 or fiscal year 1999, the Secretary  
9           shall use the amounts reported by the States not  
10          later than November 30, 2000, or November 30,  
11          2001, respectively, on HCFA Form 64 or HCFA  
12          Form 21, as approved by the Secretary.”.

13          (b) EFFECTIVE DATE.—The amendments made by  
14          this section shall take effect as if included in the enact-  
15          ment of section 4901 of BBA (111 Stat. 552).

16   **SEC. 802. PRESUMPTIVE ELIGIBILITY UNDER SCHIP.**

17          (a) APPLICATION UNDER SCHIP.—Section  
18          2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by add-  
19          ing at the end the following new subparagraph:

20                       “(D) Section 1920A (relating to presump-  
21                       tive eligibility).”.

22          (b) TECHNICAL AMENDMENTS.—Section 1920A (42  
23          U.S.C. 1396r-1a) is amended—

1           (1) in subsection (b)(3)(A)(ii), by striking  
 2           “paragraph (1)(A)” and inserting “paragraph (2)”;  
 3           and

4           (2) in subsection (c)(2), in the matter preceding  
 5           subparagraph (A), by striking “subsection  
 6           (b)(1)(A)” and inserting “subsection (b)(2)”.

7           (c) EFFECTIVE DATE.—

8           (1) IN GENERAL.—The amendment made by  
 9           subsection (a) takes effect October 1, 2000, and ap-  
 10          plies to allotments under title XXI of the Social Se-  
 11          curity Act (42 U.S.C. 1397aa et seq.) for fiscal year  
 12          2001 and each succeeding fiscal year thereafter.

13          (2) TECHNICAL AMENDMENTS.—The amend-  
 14          ments made by subsection (b) take effect as if in-  
 15          cluded in the enactment of section 4912 of BBA  
 16          (111 Stat. 571).

17   **SEC. 803. AUTHORITY TO PAY MEDICAID EXPANSION SCHIP**  
 18                           **COSTS FROM TITLE XXI APPROPRIATION.**

19          (a) AUTHORITY TO PAY MEDICAID EXPANSION  
 20    SCHIP COSTS FROM TITLE XXI APPROPRIATION.—Sec-  
 21    tion 2105(a) (42 U.S.C. 1397ee(a)) is amended—

22           (1) by redesignating subparagraphs (A) through  
 23           (D) of paragraph (2) as clauses (i) through (iv), re-  
 24           spectively, and indenting appropriately;

1           (2) by redesignating paragraph (1) as subpara-  
2           graph (B), and indenting appropriately;

3           (3) by redesignating paragraph (2) as subpara-  
4           graph (C), and indenting appropriately;

5           (4) by striking “(a) IN GENERAL.—” and the  
6           remainder of the text that precedes subparagraph  
7           (B), as so redesignated, and inserting the following:  
8           “(a) PAYMENTS.—

9           “(1) IN GENERAL.—Subject to the succeeding  
10          provisions of this section, the Secretary shall pay to  
11          each State with a plan approved under this title,  
12          from its allotment under section 2104, an amount  
13          for each quarter equal to the enhanced FMAP of ex-  
14          penditures in the quarter—

15                 “(A) for child health assistance under the  
16          plan for targeted low-income children in the  
17          form of providing medical assistance for which  
18          payment is made on the basis of an enhanced  
19          FMAP under the fourth sentence of section  
20          1905(b);” and

21          (5) by adding after subparagraph (C), as so re-  
22          designated, the following new paragraph:

23                 “(2) ORDER OF PAYMENTS.—Payments under  
24          paragraph (1) from a State’s allotment shall be  
25          made in the following order:

1                   “(A) First, for expenditures for items de-  
2                   scribed in paragraph (1)(A).

3                   “(B) Second, for expenditures for items  
4                   described in paragraph (1)(B).

5                   “(C) Third, for expenditures for items de-  
6                   scribed in paragraph (1)(C).”.

7           (b) ELIMINATION OF REQUIREMENT TO REDUCE  
8 TITLE XXI ALLOTMENT BY MEDICAID EXPANSION  
9 SCHIP COSTS.—Section 2104 (42 U.S.C. 1397dd) is  
10 amended by striking subsection (d).

11           (c) AUTHORITY TO TRANSFER TITLE XXI APPRO-  
12 PRIATIONS TO TITLE XIX APPROPRIATION ACCOUNT AS  
13 REIMBURSEMENT FOR MEDICAID EXPENDITURES FOR  
14 MEDICAID EXPANSION SCHIP SERVICES.—Notwith-  
15 standing any other provision of law, all amounts appro-  
16 priated under title XXI and allotted to a State pursuant  
17 to subsection (b) or (c) of section 2104 of the Social Secu-  
18 rity Act (42 U.S.C. 1397dd) for fiscal years 1998 through  
19 2000 (including any amounts that, but for this provision,  
20 would be considered to have expired) and not expended  
21 in providing child health assistance or related services for  
22 which payment may be made pursuant to subparagraph  
23 (B) or (C) of section 2105(a)(1) of such Act (42 U.S.C.  
24 1397ee(a)(1)) (as amended by subsection (a)), shall be  
25 available to reimburse the Grants to States for Medicaid

1 account in an amount equal to the total payments made  
 2 to such State under section 1903(a) of such Act (42  
 3 U.S.C. 1396b(a)) for expenditures in such years for med-  
 4 ical assistance described in subparagraph (A) of section  
 5 2105(a)(1) of such Act (42 U.S.C. 1397ee(a)(1)) (as so  
 6 amended).

7 (d) CONFORMING AMENDMENTS.—

8 (1) Section 1905(b) (42 U.S.C. 1396d(b)) is  
 9 amended in the fourth sentence by striking “the  
 10 State’s allotment under section 2104 (not taking  
 11 into account reductions under section 2104(d)(2))  
 12 for the fiscal year reduced by the amount of any  
 13 payments made under section 2105 to the State  
 14 from such allotment for such fiscal year” and insert-  
 15 ing “the State’s available allotment under section  
 16 2104”.

17 (2) Section 1905(u)(1)(B) (42 U.S.C.  
 18 1396d(u)(1)(B)) is amended by striking “and sec-  
 19 tion 2104(d)”.

20 (3) Section 2104 (42 U.S.C. 1397dd), as  
 21 amended by subsection (b), is further amended—

22 (A) in subsection (b)(1), by striking “and  
 23 subsection (d)”;

24 (B) in subsection (c)(1), by striking “sub-  
 25 ject to subsection (d),”.

1           (4) Section 2105(c) (42 U.S.C. 1397ee(c)) is  
2       amended—

3           (A) in paragraph (2)(A), by striking all  
4       that follows “Except as provided in this para-  
5       graph,” and inserting “the amount of payment  
6       that may be made under subsection (a) for a  
7       fiscal year for expenditures for items described  
8       in paragraph (1)(C) of such subsection shall  
9       not exceed 10 percent of the total amount of ex-  
10      penditures for which payment is made under  
11      subparagraphs (A), (B), and (C) of paragraph  
12      (1) of such subsection.”;

13          (B) in paragraph (2)(B), by striking “de-  
14      scribed in subsection (a)(2)” and inserting “de-  
15      scribed in subsection (a)(1)(C)”;

16          (C) in paragraph (6)(B), by striking “Ex-  
17      cept as otherwise provided by law,” and insert-  
18      ing “Except as provided in subsection (a)(1)(A)  
19      or any other provision of law,”.

20          (5) Section 2110(a) (42 U.S.C. 1397jj(a)) is  
21      amended by striking “section 2105(a)(2)(A)” and  
22      inserting “section 2105(a)(1)(C)(i)”.

23      (e)       TECHNICAL       AMENDMENT.—Section  
24      2105(d)(2)(B)(ii) (42 U.S.C. 1397ee(d)(2)(B)(ii)) is  
25      amended by striking “enhanced FMAP under section



1 1905(u)” and inserting “enhanced FMAP under the  
2 fourth sentence of section 1905(b)”.

3 (f) EFFECTIVE DATE.—The amendments made by  
4 this section shall be effective as if included in the enact-  
5 ment of section 4901 of the BBA (111 Stat. 552).

## 6 **TITLE IX—OTHER PROVISIONS**

### 7 **SEC. 901. INCREASE IN AUTHORIZATION OF APPROPRIA-** 8 **TIONS FOR THE MATERNAL AND CHILD** 9 **HEALTH SERVICES BLOCK GRANT.**

10 (a) IN GENERAL.—Section 501(a) (42 U.S.C.  
11 701(a)) is amended in the matter preceding paragraph (1)  
12 by striking “\$705,000,000 for fiscal year 1994” and in-  
13 serting “\$1,000,000,000 for fiscal year 2001”.

14 (b) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) takes effect on October 1, 2000.

### 16 **SEC. 902. INCREASE IN APPROPRIATIONS FOR SPECIAL DI-** 17 **ABETES PROGRAMS FOR CHILDREN WITH** 18 **TYPE I DIABETES AND INDIANS.**

19 (a) SPECIAL DIABETES PROGRAMS FOR CHILDREN  
20 WITH TYPE I DIABETES.—Section 330B(b) of the Public  
21 Health Service Act (42 U.S.C. 254c–2(b)) is amended—

22 (1) by striking “Notwithstanding” and insert-  
23 ing the following:

24 “(1) TRANSFERRED FUNDS.—Notwith-  
25 standing”; and

1 (2) by adding at the end the following:

2 “(2) APPROPRIATIONS.—For the purpose of  
3 making grants under this section, there is appro-  
4 priated, out of any funds in the Treasury not other-  
5 wise appropriated \$70,000,000 for each of fiscal  
6 years 2001 and 2002 (which shall be combined with  
7 amounts transferred under paragraph (1) for each  
8 such fiscal years).”.

9 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
10 Section 330C(c) of the Public Health Service Act (42  
11 U.S.C. 254c-3(c)) is amended—

12 (1) by striking “Notwithstanding” and insert-  
13 ing the following:

14 “(1) TRANSFERRED FUNDS.—Notwith-  
15 standing”; and

16 (2) by adding at the end the following:

17 “(2) APPROPRIATIONS.—For the purpose of  
18 making grants under this section, there is appro-  
19 priated, out of any money in the Treasury not other-  
20 wise appropriated \$70,000,000 for each of fiscal  
21 years 2001 and 2002 (which shall be combined with  
22 amounts transferred under paragraph (1) for each  
23 such fiscal years).”.

○